BRIEFING BOOK

HISTORY OF REGIONAL MEDICAL PROGRAMS

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RMP BRIEFING BOOK CONTENTS

Tab I

Introductory Statement

INTRODUCTORY STATEMENT

This briefing book is designed to provide those being interviewed in connection with NLM's history of Regional Medical Programs project, and their interviewers, with basic background information about RMPs. The book will also be useful to journalists, historians and others interested in the hsitory of RMPs. The book was prepared by NLM's History of Medicine Division with assistance from others both inside and outside the Library.

This version of the briefing book is a first draft, and comments and corrections are most welcome. Please address these to John Parascandola, Chief, History of Medicine Division, National Library of Medicine, 8600 Rockville Pike, Bethesda, MD 20894.

Tab II

Chronology of Regional Medical Programs

CHRONOLOGY OF REGIONAL MEDICAL PROGRAMS

February 1964	President Johnson delivered his "Health Message" to Congress in which he announced the establishment of a Commission on Heart Disease, Cancer and Stroke.
December 1964	The Report of the President's Commission on Heart Disease, Cancer and Stroke was issued, presenting 35 recommendations including the development of regional complexes, medical facilities and resources.
January 18, 1965	Companion bills--S. 596 and H.R. 3140--were introduced in the Senate by Senator Lister Hill (Ala.), and in the House by Rep. Oren Harris (Ark.), giving concrete legislative form to the recommendations of the DeBakey Commission.
August 1965	Anthony Celebrezze was replaced by John Gardner as Secretary of HEW.
October 1965	P.L. 89-239, the Heart Disease, Cancer and Stroke Amendments of 1965, was signed. The Commission concepts of "regional medical complexes" and "coordinated arrangements" were replaced by "regional medical programs" (RMP) and "cooperative arrangements," thus emphasizing voluntary linkages.
December 1965	National Advisory Council on RMPs met for the first time to advise on initial plans and policies.
February 1966	Dr. Robert Q. Marston appointed first Director of the Division of RMPs under NIH. He also served as Associate Director of NIH.
April 1966	First planning grants approved by National Advisory Council. Original emphasis of RMPs placed on continuing education, patient-care demonstration projects, and development of new manpower resources.
February 1967	First operational grants approved by National Advisory Council.
June 1967	The Surgeon General submitted the Report on Regional Medical Programs to the President and the Congress, summarizing progress made and recommending extension of the program.

December 1967	61 RMPs designated; only four were operational.
March 1968	Companion bills to extend RMPs were introduced in the House by Harley O. Staggers (W.Va.) as H.R. 15758 and in the Senate by Senator Lister Hill (Ala.) as S. 3094.
March 1968	Wilbur J. Cohen takes over as new Secretary of HEW. Reorganization of the Public Health Service announced.
July 1968	The Health Services and Mental Health Administration (HSMHA) is created; RMPs transferred from NIH to HSMHA. RMPs combined with eight programs of the National Center for Chronic Disease Control to form, within HSMHA, the Regional Medical Program Service. The chronic disease programs included the Cancer Program; Chronic Respiratory Disease Program; Diabetes and Arthritis Program; Heart Disease and Stroke Program; Kidney Disease Program; Smoking and Health Program; Neurological and Sensory Disease Program; and Nutrition Program.
September 1968	Meeting of all RMP program coordinators in Alexandria, VA. Five regional groups established: Northeast, Southeast, Midwest, Southwest and West.
October 1968	P.L. 90-574, extending RMPs for two years, was signed. Changes included -- expansion outside the 50 states; funding interregional activities; permission of dentists to refer patients; permission of Federal hospital participation.
January 1969	Robert H. Finch appointed Secretary of HEW in the Nixon administration.
September 1969	National meeting of coordinators of RMPs and chairmen of Regional Advisory Groups in Warrenton, VA.
FY 1969	44 RMPs were operational. Membership in various Regional Advisory Groups exceeds 2000. Over 400 operational projects were under way.
Jan-Oct 1970	Bills extending RMPs introduced; hearings held.

June 1970	Elliot L. Richardson appointed Secretary of HEW.
October 1970	P.L. 90-515 was signed into law. New provisions: emphasis on primary care and regionalization of health care resources; added prevention and rehabilitation; added kidney disease; added authority for new construction; required review of RMP applications by Areawide Comprehensive Planning agencies; emphasized health services delivery and manpower utlilization. New manpower included "physician extenders" such as nurse practitioners.
FY 1970	Of the nine original chronic disease programs, the following five were phased out: Cancer, Diabetes and Arthritis, Chronic Respiratory Disease, Heart Disease and Stroke, and Neurological and Sensory disease. The RMP Service consisted now only of RMPs, Kidney Disease Program, and National Clearinghouse for Smoking and Health. 54 RMPs were operational. Membership in various Regional Advisory Groups was 2,400.
November 1972	Caspar Weinberger appointed Secretary of HEW by Nixon.
FY1973	Peak year of funding of RMPs, with $140 million appropriated. Emergency medical services were playing an increasing role, receiving larger share of funding. Nixon administration proposes health spending cuts, including zero funding for RMPs in FY1974. Bureaucratic and local support gains a one-year extension.
July 1973	HSMHA is split into the Health Services Administration, the Health Resources Administration, and the Alcohol, Drug Abuse, and Mental Health Administration. RMPs placed in the Health Resources Administration.
1974	The National Health Planning and Resource Development Act of 1974, P.L. 93-641, consolidated RMPs with the Hill-Burton and Comprehensive Health Planning Federal programs.

February 7, 1974	In response to a law suit filed by the National Association of Regional Medical Programs, the court ordered the Secretary of HEW to release the $126 million in impounded fiscal year 1973 and 1974 funds to the nation's RMPs.
1976	After a transitional period, independent RMP operations ceased.

TAB III

RMP Enabling Legislation

SYNOPSIS OF PL 89-239 (RMP ENABLING LEGISLATION)

"Heart Disease, Cancer, and Stroke Amendments of 1965"

This act amended the Public Health Service Act by adding on to it the following:

"Title IX,-EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELDS OF HEART DISEASE, CANCER, STROKE, AND RELATED DISEASES"

Section 900. "Purposes"

a. To establish regional cooperative arrangements of medical schools, research institutions and hospitals, for the purposes of research, training, and demonstrations of patient care.
b. To make the latest advances available to the public, through such cooperative arrangements.
c. To do so without impinging upon the private health care system.

Section 901. "Appropriations"

a. $50 million for fiscal 1965.
   Those funds to be used for grants for universities and institutions for the purposes as outlined in 900 a.
b. These grants cover up to 90% of construction costs.
c. The funds are not to be used directly for patient care.

Section 902. "Definitions"

Regional Medical Program: a cooperative arrangement among a group of public or private non-profit institutions . . .

1. . . . in a geographic area to be determined by the Surgeon General.
2. . . . that includes one or more research centers and one or more diagnostic/treatment centers.
3. . . . that includes coordination arrangements of its various components.

Section 903. "Grants for Planning and Development"

a. The Surgeon General in consult with the National Advisory Council authorizes all grants.
b. Fiscal accountability is required of all grant recipients. The applicant(s) must provide an advisory group of experienced members in the health care fields.

Section 904. "Grants for Establishment and Operation of Regional Medical Programs"

EXHIBIT XII

Public Law 89–239
89th Congress, S. 596
October 6, 1965
An Act

Heart Disease, Cancer, and Stroke Amendments of 1965.

To amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and related diseases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Heart Disease, Cancer, and Stroke Amendments of 1965".

SEC. 2. The Public Health Service Act (42 U.S.C., ch. 6A) is amended by adding at the end thereof the following new title:

"TITLE IX—EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELDS OF HEART DISEASE, CANCER, STROKE, AND RELATED DISEASES

"Purposes

"SEC. 900. The purposes of this title are—

"(a) Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases;

"(b) To afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and

"(c) By these means, to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies.

"Authorization of Appropriations

"SEC. 901. (a) There are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1966, $90,000,000 for the fiscal year ending June 30, 1967, and $200,000,000, for the fiscal year ending June 30, 1968, for grants to assist public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies in planning, in conducting feasibility studies, and in operating pilot projects for the establishment of regional medical programs of research, training, and demonstration activities for carrying out the purposes of this title. Sums appropriated under this section for any fiscal year shall remain available for making such grants until the end of the fiscal year following the fiscal year for which the appropriation is made.

"(b) A grant under this title shall be for part or all of the cost of the planning or other activities with respect to which the application is made, except that any such grant with respect to construction of, or provision of built-in (as determined in accordance with regulations) equipment for, any facility may not exceed 90 per centum of the cost of such construction or equipment.

"(c) Funds appropriated pursuant to this title shall not be available to pay the cost of hospital, medical, or other care of patients except to the extent it is, as determined in accordance with regulations, incident to those research, training, or demonstration activities which are encompassed by the purposes of this title. No patient shall be furnished hospital, medical, or other care at any facility incident to research, training, or demonstration activities carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician.

"Definitions

"SEC. 902. For the purposes of this title—

"(a) The term 'regional medical program' means a cooperative arrangement among a group of public or nonprofit private institutions or agencies engaged in research, training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and, at the option of the applicant, related disease or diseases; but only if such group—

"(1) is situated within a geographic area, composed of any part or parts of any one or more States, which the Surgeon General determines, in accordance with regulations, to be appropriate for carrying out the purposes of this title;

"(2) consists of one or more medical centers, one or more clinical research centers, and one or more hospitals; and

"(3) has in effect cooperative arrangements among its component units which the Surgeon General finds will be adequate for effectively carrying out the purposes of this title.

"(b) The term 'medical center' means a medical school or other medical institution involved in postgraduate medical training and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes.

"(c) The term 'clinical research center' means an institution (or part of an institution) the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high-quality diagnostic and treatment services for inpatients and outpatients.

"(d) The term 'hospital' means a hospital as defined in section 625(c) or other health facility in which local capability for diagnosis and treatment is supported and augmented by the program established under this title.

"(e) The term 'nonprofit' as applied to any institution or agency means an institution or agency which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(f) The term 'construction' includes alteration, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

"Grants for Planning

"SEC. 903. (a) The Surgeon General, upon the recommendation of the National Advisory Council on Regional Medical Programs established by section 905 (hereafter in this title referred to as the 'Council'), is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions to assist them in planning the development of regional medical programs.

"(b) Grants under this section may be made only upon application therefor approved by the Surgeon General. Any such application may be approved only if it contains or is supported by—

"(1) reasonable assurances that Federal funds paid pursuant to any such grant will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder;

"(2) reasonable assurances that the applicant will provide for such fiscal control and fund accounting procedures as are required by the Surgeon General to assure proper disbursement of and accounting for such Federal funds;

"(3) reasonable assurances that the applicant will make such reports, in such form and containing such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports; and

"(4) a satisfactory showing that the applicant has designated an advisory group, to advise the applicant (and the institutions and agencies participating in the resulting regional medical program) in formulating and carrying out the plan

for the establishment and operation of such regional medical program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program and members of the public familiar with the need for the services provided under the program.

"Grants for Establishment and Operation of Regional Medical Programs

"SEC. 904. (a) The Surgeon General, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions to assist in establishment and operation of regional medical programs, including construction and equipment of facilities in connection therewith.

"(b) Grants under this section may be made only upon application therefor approved by the Surgeon General. Any such application may be approved only if it is recommended by the advisory group described in section 903(b)(4) and contains or is supported by reasonable assurances that—

"(1) Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) will not supplant funds that are otherwise available for establishment or operation of the regional medical program with respect to which the grant is made;

"(2) the applicant will provide for such fiscal control and fund accounting procedures as are required by the Surgeon General to assure proper disbursement of and accounting for such Federal funds;

Records.

"(3) the applicant will make such reports, in such form and containing such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports; and

"(4) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"National Advisory Council on Regional Medical Programs

Appointment of members.

"SEC. 905. (a) The Surgeon General, with the approval of the Secretary, may appoint, without regard to the civil service laws, a National Advisory Council on Regional Medical Programs. The Council shall consist of the Surgeon General, who shall be the chairman, and twelve members, not otherwise in the regular full-time employ of the United States, who are leaders in the fields of the fundamental sciences, the medical sciences, or public affairs. At least two of the appointed members shall be practicing physicians, one shall be outstanding in the study, diagnosis, or treatment of heart disease, one shall be outstanding in the study, diagnosis, or treatment of cancer, and one shall be outstanding in the study, diagnosis, or treatment of stroke.

Term of office.

"(b) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term

for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Surgeon General at the time of appointment, four at the end of the first year, four at the end of the second year, and four at the end of the third year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms.

Compensation.

"(c) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently.

Applications for grants, recommendations.

"(d) The Council shall advise and assist the Surgeon General in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this title. The Council shall consider all applications for grants under this title and shall make recommendations to the Surgeon General with respect to approval of applications for and the amounts of grants under this title.

"Regulations

"SEC. 906. The Surgeon General, after consultation with the Council, shall prescribe general regulations coverng the terms and conditions for approving applications for grants under this title and the coordination of programs assisted under this title with programs for training, research, and demonstrations relating to the same diseases assisted or authorized under other titles of this Act or other Acts of Congress.

"Information on Special Treatment and Training Centers

"SEC. 907. The Surgeon General shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer, or stroke, together with such related information, including the availability of advanced specialty training in such facilities, as he deems useful, and shall make such list or lists and related information readily available to licensed practitioners and other persons requiring such information. To the end of making such list or lists and other information most useful, the Surgeon General shall from time to time consult with interested national professional organizations.

Report to President and Congress

"SEC. 908. On or before June 30, 1967, the Surgeon General after consultation with the Council, shall submit to the Secretary for transmission to the President and then to the Congress, a report of the activities under this title together with (1) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, (2) an appraisal of the activities assisted under this title in the light of their effectiveness in carrying out the purposes of this title, and (3) recommendations with respect to extension or modification of this title in the light thereof.

"Records and Audit

"SEC. 909. (a) Each recipient of a grant under this title shall keep such records as the Surgeon General may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of

the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any grant under this title which are pertinent to any such grant."

SEC. 3. (a) Section 1 of the Public Health Service Act is amended to read as follows:

"SECTION 1. Titles I to IX, inclusive, of this Act may be cited as the 'Public Health Service Act'."

(b) The Act of July 1, 1944 (58 Stat. 682), as amended, is further amended by renumbering title IX (as in effect prior to the enactment of this Act) as title X, and by renumbering sections 901 through 914 (as in effect prior to the enactment of this Act), and references thereto, as sections 1001 through 1014, respectively.

APPROVED OCTOBER 6, 1965, 10:15 A.M.

Legislative History:

House Report No. 963 accompanying H.R. 3140 (Comm. on Interstate and Foreign Commerce).
Senate Report No. 368 (Comm. on Labor and Public Welfare).
Congressional Record, Vol. 111 (1965):
June 25: Considered in Senate.
June 28: Considered and passed Senate.
Sept. 23: H.R. 3140 considered in House.
Sept. 24: Considered and passed House, amended, in lieu of H.R. 3140.
Sept. 29: Senate concurred in House amendments.

TAB IV

Useful Summary Articles

USEFUL SUMMARY ARTICLES

Robert Q. Marston and Karl Yordy, "A Nation Starts a Program: Regional Medical Programs, 1965-1966," J. Med. Educ., 42 (1967): 17-27.

Paul D. Ward, "The Curious Odyssey of Regional Medical Programs," West. J. Med., 120 (1974): 425-429.

Caspar W. Weinberger, "The Guideposts in the RMP Odyssey," West. J. Med., 121 (1974): 158-160.

A Nation Starts a Program: Regional Medical Programs, 1965-1966*

ROBERT Q. MARSTON, M.D.† AND KARL YORDY‡
National Institutes of Health, Bethesda, Maryland

This month [October, 1966] marks the first anniversary of P. L. 89-239, the Heart Disease, Cancer and Stroke Amendments signed by President Johnson on October 6, 1965. The legislation was hailed by some as a landmark in the history of American medicine. It was strongly criticized by others, both for what it said and what it did not say. Even some of those who supported the legislation in principle still maintained a wary curiosity concerning the implementation of such general legislative language. The philosophical hopes and fears of a year ago have been replaced by actual events, real problems, and identifiable progress. It is appropriate at this time to report on the extent to which the Regional Medical Programs legislation has been implemented.

It is estimated that there will be 48 or 49 programs: 45 planning grant applications or declarations of intent have been submitted to date. These programs will actually be defined in large measure through the activity of those people who will make them operative. It is this characteristic of the Regional Medical Programs that makes them a fascinating experiment in federal health policy.

Obviously, experience with the development of these programs is still quite limited, and many of the difficult problems being encountered in implementing this legislation are influenced by large issues and historical trends which can be seen only incompletely at any one time and from any one place.

While the historian of the future will focus on forces that we can perceive only dimly at present, reflection on the possible impact of the programs brings to mind a view of history presented by Robert Bolt (1) in *A Man For All Seasons.* His theme is that an examination of the trends and forces will illuminate only a portion of any historical event. What is of interest is the way it happened, the way it was lived. " 'Religion' and 'economy' are abstractions which describe the way men live. Because men work we may speak of an economy, not the other way round. Because men worship we may speak of religion, not the other way round."

BACKGROUND

There are a number of long-range factors and trends which constitute a common heritage for the Regional Medical Programs and which set the scene for the passage of the authorizing legislation. The most important of these factors is the impact of science on the nature of medicine and medical practice. The dynamic growth of medical research in this country during the past twenty years and the resulting advances in knowledge form the scientific base which is the beginning point for the program. Following are some of the factors which contributed to the development of the legislation:

* Presented at the 77th Annual Meeting of the Association of American Medical Colleges, San Francisco, October 22, 1966.

† Associate Director; Director, Division of Regional Medical Programs.

‡ Assistant Director, Division of Regional Medical Programs.

the forty-year discussion on regionalization of medical services; the evolution of the medical schools with the accompanying development of great medical centers; and underlying social factors relevant to health concerns, including the rising expectations of the consumer of health services who is increasingly coming to expect that modern medical science will have the solutions to his health problems.

The legislation was directly influenced by such publications as the Coggeshall Report, *Planning for Medical Progress through Education* (2); the Dryer Report, "Lifetime Learning for Physicians" (3); and the Reports of the Association's Eighth and Tenth Teaching Institutes "Medical Education and Medical Care: Interactions and Prospects" and "Medical Education and Practice: Relationships and Responsibilities in a Changing Society" (4, 5). However, the actual impetus for the introduction of the bill was the publication of the Report of the President's Commission on Heart Disease, Cancer and Stroke (6), which focused on the relationship between science and service in medicine. The mandate of the President's Commission did not include the drafting of legislation; that task was performed under the leadership of Dr. Edward Dempsey, then Special Assistant to the Secretary of the Department of Health, Education, and Welfare for Health and Medical Affairs, and Dr. Dempsey's Assistant, Dr. William Stewart, now Surgeon General. The bill that was sent to the Congress by the Administration contained the elements which have proved to be most important to the development of the program over the past year, including the emphasis on the relationship of academic medicine to medical practice, the creation of workable cooperative arrangements among health resources, and the use of competitive grants rather than formula grants.

Congress did not rubber stamp the Administration's proposal. Many changes were made in the original bill, primarily as the result of hearings before the House Interstate and Foreign Commerce Committee, chaired by Congressman Oren Harris. By its action, Congress made it clear that this program would be built upon cooperation among existing institutions and that local initiative would play a determining part in the development of the Regional Medical Programs. The law emphasized the role of the required regional advisory group and the intent that this group be broadly representative of all health interests and include practicing physicians and representatives of the interested public.

The House Committee was impressed with the potential contribution that the Regional Medical Programs could make to the more effective utilization of manpower. Therefore, it stressed the role of continuing education and training in accomplishing the purposes of the legislation.

Although the bill as originally written provided authority for new construction, this section was eliminated before the legislation was passed.

Finally, Congress authorized the program for three years and made clear its intent that this initial period be an exploratory phase which would constitute the learning experience on which future extension and modification of the legislation could be based.

Preceding the signing of the legislation, the administrative decision was made that this new responsibility of the Public Health Service would be administered by the National Institutes of Health. This action emphasized the fact that the Regional Medical Programs concept focused on the relationship and interaction between the development of new knowledge and the provision of better medical care. In the period preceding and following the final approval of the legislation, Dr. Stuart Sessoms, Deputy

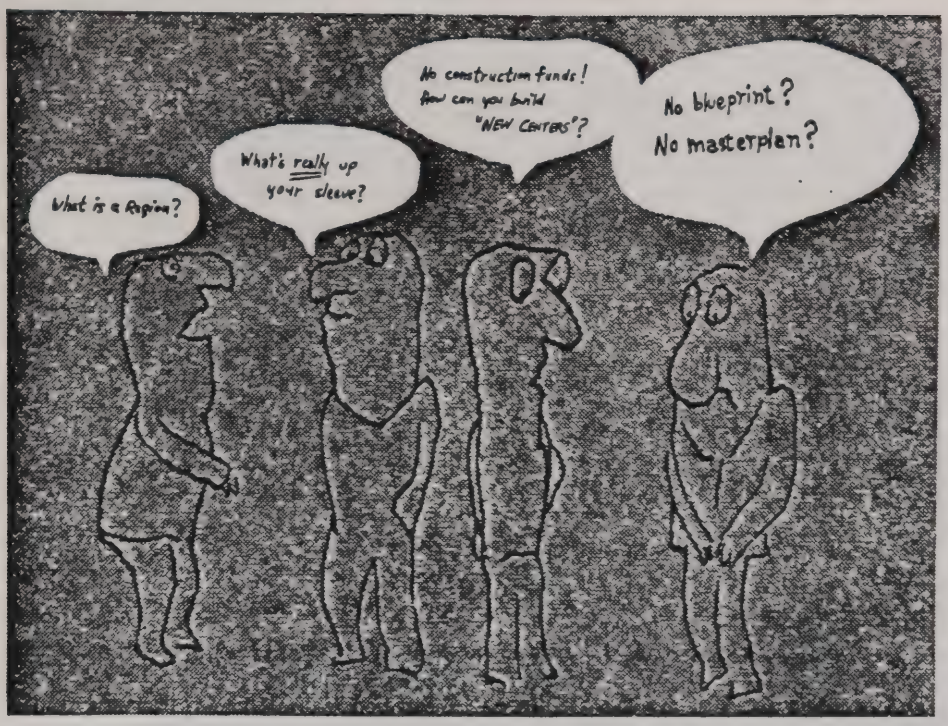


FIGURE 1

Director of NIH, was the focal point for NIH concern with this legislation, assisted by Mr. Karl Yordy. Much of the early implementation which will be described later in this paper occurred under the leadership of Dr. Sessoms, who bore the major responsibilities until February, 1966.

On October 6, 1965 there were no experts on regional medical programs, no master blueprints of how a regional medical program would work. During this period, questions from prospective applicants and other interested parties attempted to probe the flexibility of the legislation in order to determine whether or not there was a specific blueprint for implementation (Figure 1). How do you define a region? How many regions will there be? Who can apply? What will be the responsibilities of the applicant? What is the exact nature and role of the regional advisory group? Tell me in specific terms what a regional medical program will do and how it will function. The answers, or some would say lack of answers, to these questions reflected the fact that the flexibility of this legislation was deliberate public policy and that this flexibility is central to the concept of a regional medical program.

The legislation clearly prescribed that the program be carried out on a regional rather than a national basis. The law represents a vote of confidence in the willingness of the regions to accept the basic responsibility for devising the programs to accomplish the purposes of the law. The flexibility of the legislative provisions highlights this transference of responsibility to the regional level. A clearly defined national medical program would have led to fewer questions. However, even if workable, it would have meant less opportunity for creativity, fewer opportunities to develop diverse answers appropriate to diverse problems, and less assumption of responsibility at the local level.

After one year of experience, there is considerable evidence justifying this law's almost naïve trust and faith in the ability of formerly divergent medical interests to cooperate on a voluntary

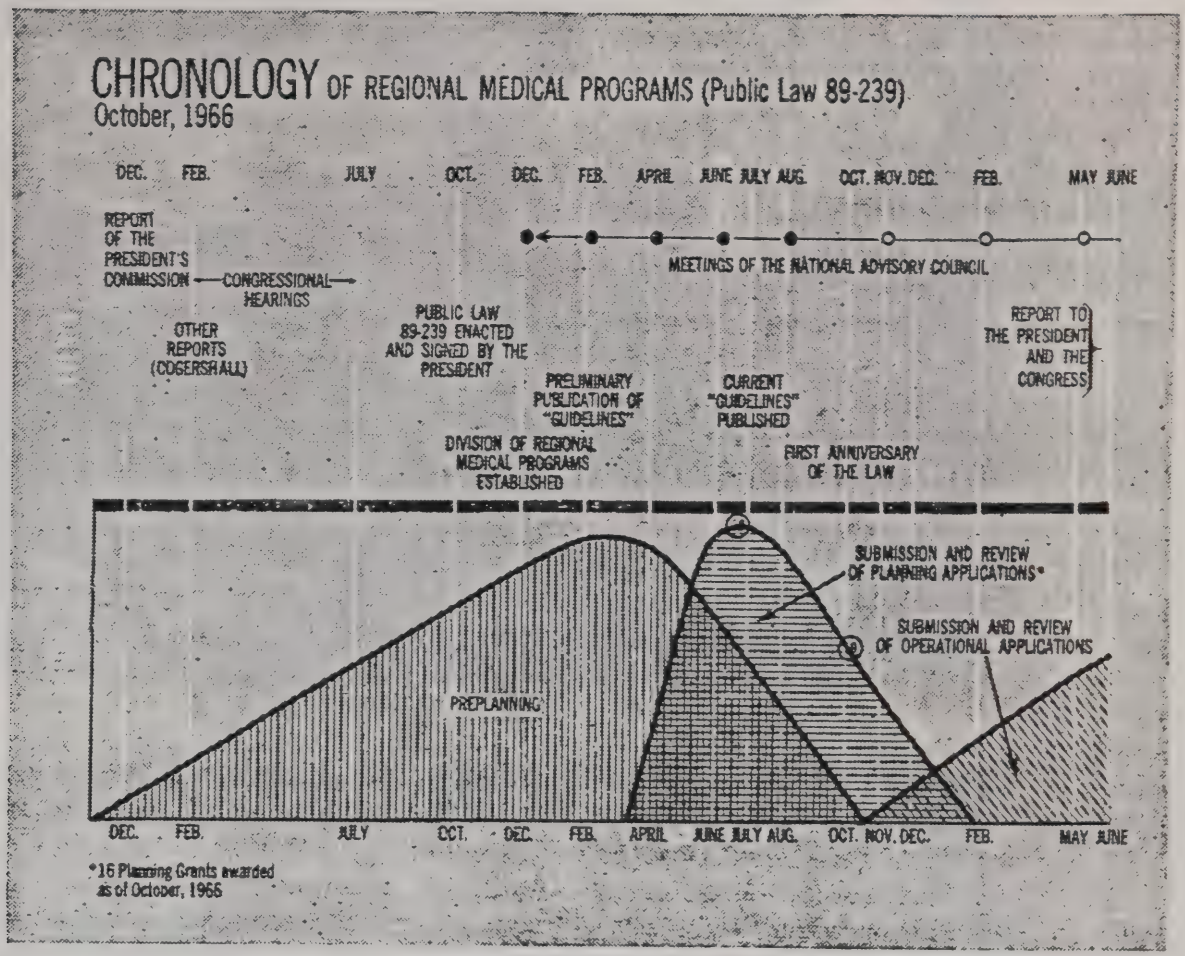


FIGURE 2

basis in accomplishing important health objectives.

DEVELOPMENT

REASSURANCE AND DEFINITION

Experience with the program divides naturally into several phases (Figure 2). The first spans the period from the signing of the legislation in October until about February, 1966. During this time, much of the effort of Dr. Sessoms, the authors, and others was spent in providing reassurance to various medical groups concerning the nature of this program as defined in the law. For some still feared that the program would be a federal medical system which would divert patients to distant medical centers with no concern for the role of the local practicing physician or hospital. Some of the medical school faculty and administrators feared that their medical centers were being asked to assume the total responsibility in their regions for medical care in the fields of heart disease, cancer, and stroke. Nonaffiliated hospitals feared that they would have no role to play in the program (Figure 3).

However, along with the fears and anxieties, there was a ground swell of interest in the Regional Medical Programs expressed by a very wide variety of health organizations, institutions, and individuals. Meetings were held in regions throughout the country to discuss implementation of the program. The staff at NIH was contacted by literally hundreds of medical organizations and groups expressing interest and support. The Regional Medical Programs appeared as a

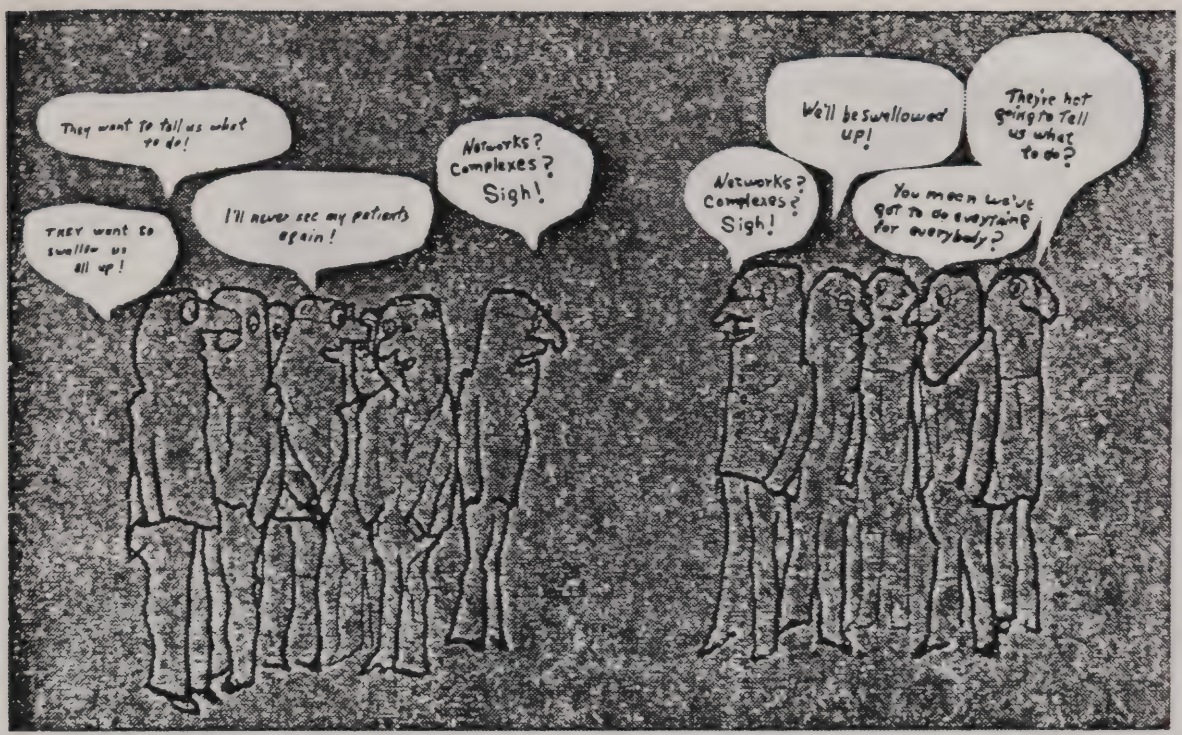


FIGURE 3

topic for discussion in the programs of a number of major medical professional organizations.

In December the Division of Regional Medical Programs was established and its National Advisory Council held its first meeting.

REGULATIONS, GUIDELINES, AND OUTLINES

The second phase of the program extended from February until April. Special groups of consultants with expertise in such relevant fields as continuing education, community health planning, and hospital administration were called together to advise the Division on the implementation of the program. Regulations were drafted and proposed. Preliminary guidelines for applications and the application forms themselves were developed and widely distributed. Another meeting of the National Advisory Council was held and a process for the review of applications was developed, consisting of a preliminary review by staff and by a group of *ad hoc* consultants prior to the review by the National Advisory Council as required by the law. Members of the Council and the *ad hoc* consultants became increasingly articulate in interpreting and defining the program in speeches, in their own professional organizations, and in the development of individual regional plans.

RECEIPT AND REVIEW OF APPLICATIONS

The period from April through June constituted the third program phase. During this time, the emphasis changed from reassurance, definition, and preparation to the receipt of applications for planning grants and the review of those applications (Figure 4). No deadlines for the receipt of applications were publicized. Instead, it was the Division's stated intention to hold frequent review meetings so that applications could be considered without undue delay and without the development of a crash program. Therefore, the National Advisory Council met to consider applications in April, June, and August, preceded each time by a meeting of an *ad hoc* initial review

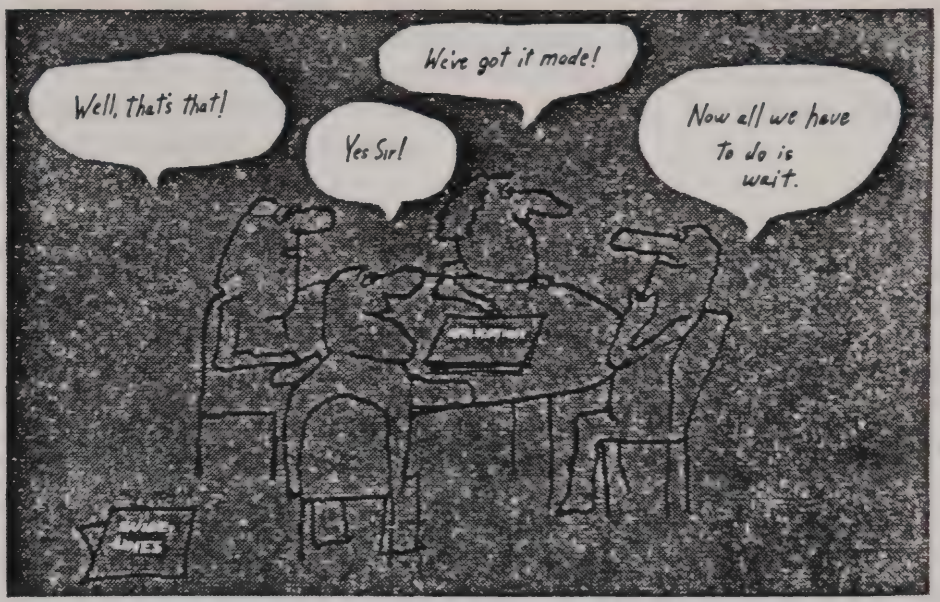


FIGURE 4

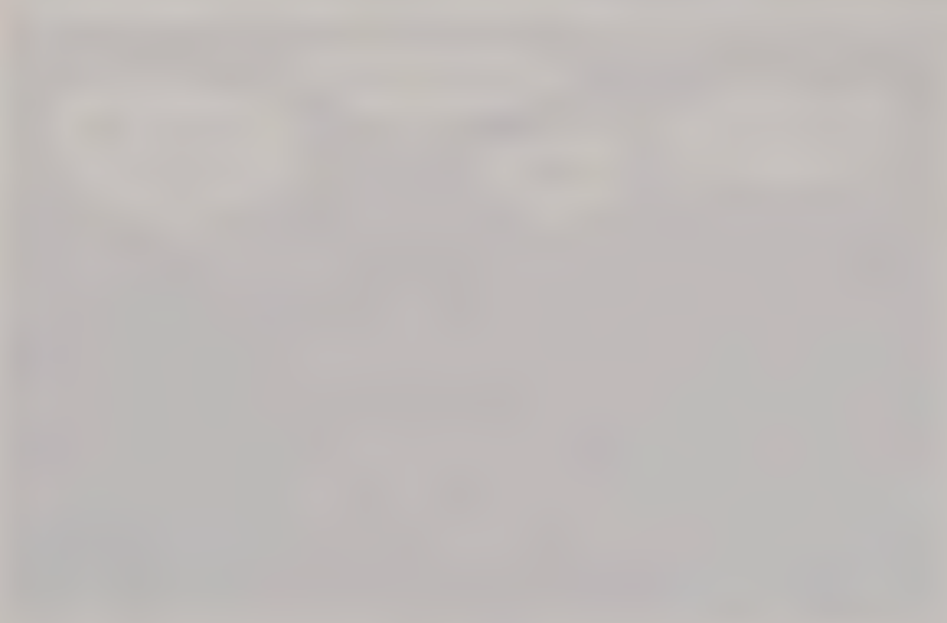
group representing a variety of backgrounds in health affairs. These groups were able to consider applications with varying approaches to the planning of a regional medical program and reach a consensus on the merits of the proposals in terms of the purposes of the law. During this phase, 39 planning-grant applications were received—overwhelming evidence of the willingness of regional groups throughout the country to accept responsibility for the development of a planning program.

In reviewing the first applications, the Division was able to identify certain areas of emphasis and problems, which were then reflected in the organization of the Division's staff and development of Division policies. Examples are the consideration given to continuing education as a major function of the Regional Medical Programs and the proposed large-scale use of systems analysis techniques in the planning of specific regional medical programs. As a result, the guidelines document (7) issued by the Division on July 1 was based not only on the intent of the Congress and the judgment of the National Advisory Council and other advisors but also on experience in the actual review of planning-grant applications.

NEGOTIATIONS AND ANTICIPATION

During the final phase of the first year of the program, lasting from June until October, concern was with (*a*) continued review of applications for planning grants; (*b*) a rapid buildup of activities in continuing education; (*c*) preparation for the required Report to Congress in June, 1967; and (*d*) anticipation of applications for operational grants.

In considering the applications, the review groups found that a straight "yes" or "no" answer was seldom sufficient to communicate the intent of their actions. Therefore, the National Advisory Council requested that the Division staff discuss with each applicant the action that was taken and the reasons for that action. It was felt that this interchange and discussion between the applicant group and the staff of the Division would contribute to a better understanding on both sides of the nature of the proposal. On many applications the National Advisory Council required that additional information be obtained from the applicant before the application could be



recommended for approval and a grant awarded. When the additional information requested would not affect the basic soundness of the proposal, the Council recommended approval, conditional upon receipt by the Division of clarifying information. If the information to be provided was more substantial, the Council deferred action on the application until it could consider the additional information supplied by the applicant. On other applications the Council did not feel that it could recommend approval of the application until substantial revisions had been made in the proposal. In recommending revisions, the Council emphasized the fact that it expected to see the revised application at its next review meeting and that in negotiating these revisions, the staff of the Division would not require that applications conform to a standard pattern. The Council wanted these applications to retain their unique characteristics; but it felt a strong sense of responsibility that the award of federal grant funds could only be recommended after satisfactory evidence had been presented that the proposal, whatever its proposed approach, could reasonably be expected to result in a plan for a regional medical program that accomplished the objectives of the legislation.

This phase of the program saw the appointment of a blue ribbon *ad hoc* committee, which has now had 2 meetings to focus on the Surgeon General's Report to the President and Congress, due June 30, 1967. Also during this phase, initial plans were made for a national meeting to be held January 16-17, 1967 in response to a number of requests for such a meeting and also because of the need to get grass-roots opinion for the Report to Congress.

At this time, a change in the types of questions which medical groups asked staff representatives became apparent, primarily because increasingly large proportions of audiences had actively participated in the development of applications. Actually, many have now given in their regions the same type of talks staff members were giving a few short months ago.

PLANNING-GRANT APPLICATIONS

One of the most productive sources of information at this relatively early stage of the program has been the grant applications themselves. They provide preliminary insights into the types of activities to be carried out on behalf of the Regional Medical Programs as well as a rough gauge of the extent to which "regional cooperative arrangements" among medical schools, research institutions, hospitals, and other health agencies and institutions have developed to date.

Forty-three applications have been recommended for approval or are currently under consideration. They cover regions which contain about 80 per cent of the nation's population. Certain of the major metropolitan centers account for most of the remainder of the population. As might have been expected, multi-medical-center urban areas have had particularly difficult problems in developing the cooperative arrangements essential to the Regional Medical Programs. However, pending applications and discussions with groups in New York, Philadelphia, Chicago, and Boston, for instance, have led to the conviction that effective ways will be found of bringing together the many health interests that exist in these urban areas.

The applications which have been received indicate that the initial planning of the Regional Medical Programs will generally include 4 major types of activities: (*a*) organization and staffing; (*b*) studies to collect and analyze data on resources, problems, and needs; (*c*) development of ways to strengthen communications and relationships among the health institutions and agencies of the region;

and (*d*) preparation of proposals for operational projects.

The approaches to the organization and staffing of the programs vary widely.

In a majority of cases (26), the formal applicant—the institution acting as the "programming headquarters" or "agent" for the region—has been a medical school; this situation is particularly likely when there is only one medical school in the region and that institution is part of a state university system. There have been 4 applications from medical societies, 2 from existing private nonprofit agencies, and one from a state agency. In 10 of the 43 regions new corporations have been established to be the applicant. It has been suggested that these new organizations may be of considerable significance for the development of more effective cooperation among major health resources.

In addition to the applicants themselves, well over 400 other cooperating agencies or institutions are represented in the applications, with hospitals, both affiliated and nonaffiliated, constituting the largest group. Among the other key participants are medical societies and state or municipal health agencies.

It is clear from the applications that utilization of existing health personnel is planned; experienced senior health administrators and educators are being sought and found to fill major positions. It is also evident that many of the grantees will be looking to other disciplines and to other university faculties for assistance. For example, there have been a number of proposals for the participation of such individuals as sociologists, economists, and communication specialists. In addition, applicants will seek advice and assistance in areas such as computer technology and operations research on a contractual basis, either from universities or from private firms.

The surveys which are most commonly mentioned in the applications are concerned with the collection of data on health manpower, facilities, and specialized capabilities. Most of the applications include proposed studies of the distribution of and needs for medical and nursing manpower. They also give high priority to problems associated with the shortages of laboratory and other allied health personnel.

Most of the applications include plans for continuing education activities for allied health personnel as well as for physicians, dentists, and nurses.

The strengthening of communications and relationships among the existing and potential participants in the Regional Medical Programs through a variety of devices is planned.

In view of the critical importance of cooperative arrangements in the programs, the following delineation of the membership of the regional advisory groups may provide an initial measure of how effective the programs are likely to be in engendering these arrangements:

1. Practicing physicians and medical center officials *each* make up about 20 per cent of these advisory groups.

2. Hospital administrators, representatives of the voluntary health agencies, other health professionals, and public health officials *each* account for about 13 per cent of the total.

3. "Public" members, including lawyers, industrialists, labor leaders, and housewives, account for the remaining 8 per cent.

4. The state governors have been involved, in one way or another, in about one-half of the cases.

5. The state health officer or a member of the state board of health from the staff of related health departments is a member of the regional advisory group in almost every case.

6. Staff members of area-wide hospital planning agencies are members of about one-half of the groups. In all other cases a representative of the appropriate hospital association is named.

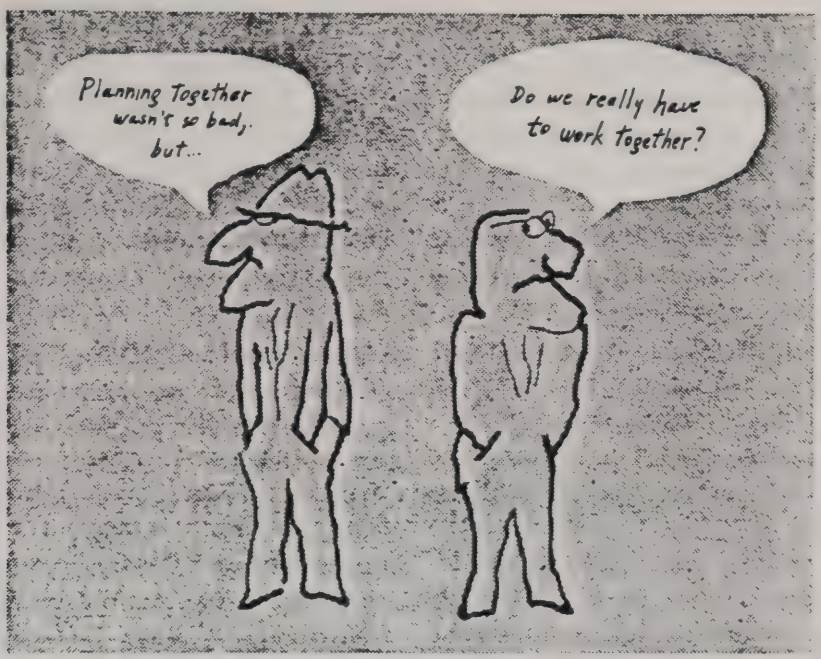


FIGURE 5

7. The groups have representation from heart associations and cancer societies.

OPERATIONAL GRANTS

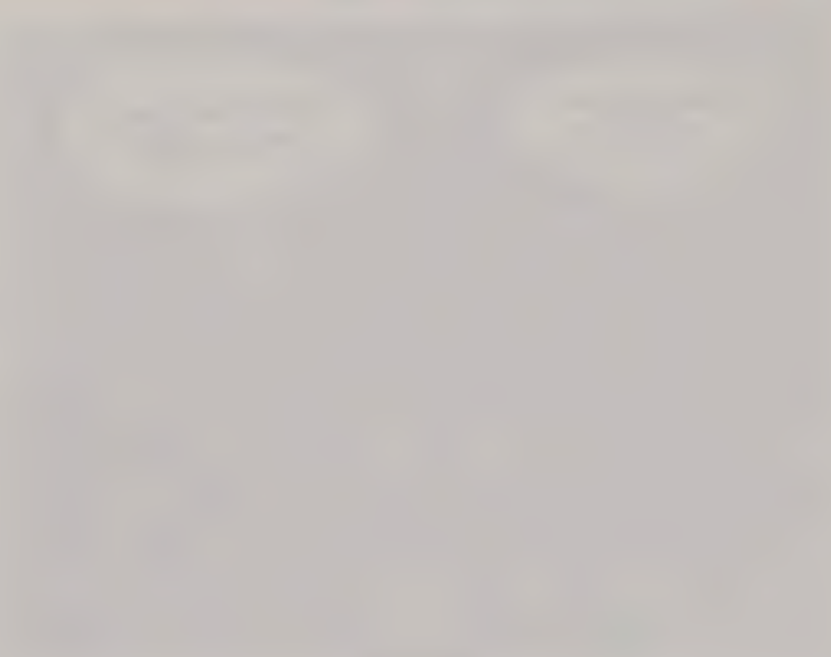
The purpose of the planning grants is to develop operational programs (Figure 5). While continued planning is a crucial part of the programs, it is anticipated that only a few new planning grants will be submitted and that increasingly the focus will be on the need for supplemental support for planning and for the initiation of operational components. A number of applications for operational grants have been submitted or are in preparation.

The Division has been deeply involved in the development and clarification of the review and approval processes which will be required for these applications. As a result of this study, it has become apparent that this process must establish 3 new types of relationships:

1. There must be a continuing and specific relationship between the Division staff, the review committee (now appointed on a permanent basis), the National Advisory Council, and the grantees. The frequent meetings of both the review committees and the National Advisory Council as well as the extensive staff negotiations with applicants represent beginnings in the development of these relationships. The creation of a branch for consultation and assistance under the direction of Dr. Margaret Sloan resulted from a recognition of this need. Further, applicants are being advised to make free use of supplemental applications so that their programs can more easily be developed by incremental steps.

2. It is necessary to develop flexible but specific involvement of other federal and nonfederal sources of support, including their review and approval processes. It is recognized that just as the program calls for an integrating and synthesizing activity on the regional level, the Division has a synthesizing and integrating responsibility to the grantees. In some instances it is clear that specific procedures must await the opportunity to work with concrete examples.

3. The review and approval process developed on the national level must be related to the review and approval mechanisms which exist in the various regions. Basic to the goal of establishing the decision-making mechanisms on the local level is the assumption that different priorities exist in different parts of



the country. However, neither the National Advisory Council nor the Public Health Service can delegate its fundamental responsibility and accountability for the wise expenditure of federal funds.

The mechanisms of the review process can be simply described. The regular process will be a familiar one: grants will be received and reviewed by the initial review committee; additional information will be gained by site visits, which in many instances will be conducted by members of both the committee and the Council; and then there will be a recommendation by the Council and the final action involving administrative decisions by the Public Health Service. In addition to this regular process the staff will custom-tailor the review process to meet the particular needs of individual grants. In many instances this will mean obtaining additional information on scientific merit or other aspects from the existing expertise in other institutes or bureaus of the Public Health Service or other agencies in the government to insure that acceptable standards are maintained; and it will also involve exploring the potentialities for support.

The development of a decision-making process in each region is a prerogative of that region, and much time and effort have already been devoted to this area by the Division and by applicants throughout the nation. Some factors relevant to evolving effective processes seem to be either easily identifiable or particularly pertinent: (*a*) The initiation of the first steps in the operational program along with continued planning should represent movements toward the fuller development of the regional program. (*b*) On the one hand there will be a need to determine the appropriate balance between dependence on retrospective data, opinions, and the experiences of others, and on the other hand there will be the need to initiate activities which will themselves provide the basis for future decisions. The law anticipates the use of research and experiments, and the initiation of activities which, when evaluated, can be modified as indicated. (*c*) Criteria for specific projects must be developed. The scope and flexibility of this legislation is such that there is no difficulty in listing great numbers of meritorious and needed projects which could be supported. Suggested criteria for setting priorities are as follows:

1. The degree to which the project would assist in the wise utilization of manpower. As one applicant noted, the regional group is not interested in tying up resources with fine projects for which the necessary manpower is not readily available.

2. The degree to which proposed projects involve multiple institutions and types of institutions and, therefore, would lead to more effective development of cooperative arrangements, particularly in the initial steps.

3. The degree to which the proposed project relates science to service.

4. The degree to which the project will contribute to continuing education and training for physicians and other health personnel.

5. The degree to which latent talent or unique regional resources might be utilized more effectively.

6. The degree to which the proposed project represents a critical area which, if supported, will beneficially affect a larger program. A regional medical program offers the opportunity to bridge gaps and to support new and innovative approaches which of themselves may be only a small portion of much more extensive activities.

Finally, of course, the fact that this is a broadly categorical program in the area of heart disease, cancer, and stroke must be taken into consideration.

The Division has been convinced that as the programs proceed into the operational phase, grantees will be well ad-

vised to select those activities which they can see clearly, rather than depending on the development of some master plan in vague and unexplored areas. Therefore, it is anticipated that many will choose those initial steps which will contribute to further refinement of the basic decision-making processes which they have established.

As those who are involved in the program move along this not uncomplicated path, it is worth remembering the way a dean once described the problem of the vice president for health affairs in bringing together groups with nonidentical goals. After speaking to the value of such activities, he raised a word of caution in the following way:

> What do they do? In short they try to hitch mules and cows to the same plow and then drive the rig. What do they try to do? They try to assemble the team, work together, combine assets, etc. To continue to enlarge upon our metaphor of hitching two thousand-pound beasts together without recognizing that the objective of one is to pull and the other to be milked could end with one going unmilked and the other sitting down. Both have highly and equally commendable objectives, but working together as a team neutralizes the effectiveness of each.

The goal of the Regional Medical Programs, like that of the vice president for health affairs, is to make the activities of its members more effective in their pursuit of their own goals.

CONCLUSION

The success of the Regional Medical Programs requires that medical schools as well as all other participants share authority as well as responsibility. Gardner (8) made the following statement in his monograph, *Self-renewal: The Individual and the Innovative Society:*

> Every great creative performance since the initial one has been in some measure a bringing of order out of chaos. It brings about a new relatedness, connects things that did not previously seem connected, sketches a more embracing framework, moves toward larger, more inclusive understanding.

The beneficial changes which have been effected by the program twenty years from now will depend upon the extent to which it has stimulated creative performances which have contributed to constant improvement in the quality of medical service in the nation.

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The Curious Odyssey of Regional Medical Programs

PAUL D. WARD, *Oakland*

DURING ITS EIGHT YEARS of existence, Regional Medical Programs (RMP) has developed a history marked by many changes of fortune. No social program enacted after World War II has experienced the ups and downs, the changes in direction, or the praise and vilification that have befallen RMP. Some programs like Model Cities and the Office of Economic Opportunity (OEO) have peaked and then fallen from grace, but none have had the spectacular roller-coaster ride of RMP. Those involved in the program believe RMP has proven its worth and provided many improvements in the health care system, but it has also served to test the stamina of those directly involved in the program, for it has been like riding the roller-coaster through a wind tunnel with the wind direction changing every few minutes.

The changes of fortune have resulted mostly from an unusual number of changes in philosophy at the top level of the Department of Health, Education and Welfare, the multitude of quarrels HEW has had with Congress, and the intrusion of the Office of Management and Budget into program decisions (which OMB is ill-equipped to enter, especially in the health care field where its expertise barely equals zero). Finally, the courts have entered the scene, with a ruling that the program should be returned to the course charted by Congress and that the funds appropriated by Congress should be made available for the purposes of the program. If we could end the story on that note, it would be like the classical novel plot: the beginning, the problems faced in the middle, and the happy ending. But in real life, there is probably more trauma to come.

In the beginning, the intent of the legislation was to create a partnership consisting of major segments of health providers, educators, public and voluntary health agencies and other health resources. While these new "cooperative arrangements" were to be carried out with an emphasis on heart disease, cancer, stroke and related diseases, there was an implicit, though unstated, acknowledgement that the potentially confining restraints of a purely categorical approach to good health care left room for other experimental activities. In any case, the overall objective was to make high quality medical care more uniformly available to every American. For more than three years this view of Regional Medical Programs held sway: Partnerships were developing among medical centers, the health professions and facilities designed to provide a single quality of medical care largely of a categorically-linked nature through voluntary cooperative arrangements; and, without interfering with established patterns of medical practice, to disseminate new knowledge to doctors, nurses and other health professionals through programs of continuing education.

In the spring of 1970 there were stirrings in the high-reaches of the Department of Health, Education and Welfare. The department issued a set of recommended national priorities for health. Emphasis was placed on the quantity side of med-

The author is Executive Director of the California Regional Medical Program.

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Reprint requests to: P. D. Ward, Executive Director, California Regional Medical Program, 7700 Edgewater Drive, Oakland, CA 94621.

ical care, with quality relegated to a secondary role. Special effort was to be made to serve the needs of the poor, including particularly the American Indians, urban and rural poor, migrant farm families, children under five and women of child-bearing age who might not otherwise be able to receive appropriate contraceptive counseling. "Primary care" was described by national leaders in favorable terms, and was to be developed for those Americans who, for a variety of reasons, were not able to seek or find necessary medical care in their own communities.

Regional Medical Programs had been enacted as Title IX of the Public Health Service Act. With the exception of Medicare, Medicaid and Maternal and Child Health, most federal health programs are a part of the Public Health Service Act and are subject to extension by Congress at least every three years. When the Administration introduced its bill in 1969 to extend Regional Medical Programs, the emphasis on categorical programs was gone. Primary care and creation of new kinds of health care services were in the ascendancy, and the proscription against interfering with traditional patient care patterns had been deleted. Congress modified the Administration's desires, keeping the categorically-related activities, adding kidney disease, and retaining the restriction against interfering with established medical care practice patterns. Notwithstanding this sentiment, Administration spokesmen continued to speak favorably of RMP's as the proper vehicle for promoting new patterns of medical care and new forms of health manpower.

About this time, however, the practice of "forced carryover" of funds began. "Forced carryover" is federalese meaning that OMB or the fiscal people in the department embargo a part of the money Congress has appropriated for a program and carry it over to the following year, usually for the purpose of reducing the next year's appropriation. It is a means of whipping a program into line—of warning it to revamp its behavior and purposes, or perish. This revamping always proves difficult for some if it violates the intent of the law, and disturbing to others as they see their commitments to local people who are cooperating voluntarily with the program upset by the change in purpose. Also, it is a sure way to throw consternation, confusion, distrust and depression into the working ranks of a program. There is no surer way to reduce the productivity and momentum of any program, if that is the intent.

The Administration took the next step shortly thereafter by introducing its proposed budget for fiscal 1972, in which the language called for a "stronger discriminatory policy which will be applied in awarding grants to individual regional medical programs." "As a result," the budget language continued, "a sharp retrenchment in grant awards will be made for those regional medical programs which have been the least productive in order to support selected increases for those regional medical programs which have shown the greatest innovative potential for moving the local health care system toward improved accessibility and quality of care.

"The major shift in emphasis by the regional medical programs will be directed toward improved and expanded service by existing physicians, nurses and other allied health personnel; new and specific mechanisms that provide quality control and improved standards and decreased costs of care in hospitals; early detection of disease; implementation of the most efficient use of all phases of health care technology; and supporting the necessary catalytic role to help initiate necessary consolidation or reorganization of health care activities to achieve maximum efficiency."[1] Thus, it was a new direction, with the emphasis on health care economics in place of the legislated purposes of quality and regionalization.

Regardless of the advisability of Regional Medical Programs taking on these responsibilities (several of which were new and, many observers thought, inappropriate for RMP), even if they were to have been carried out the budget managers were willing to provide only $52.4 million in new money, about half what had been available in 1971. It became more apparent that the Administration expected Regional Medical Programs to concentrate on delivery of primary care, emergency medical services, health manpower development and cost containment, with categorical and continuing education program activities held to a minimum. In fact, the term *continuing education* was to become one not to be politely used.

The authorization for new money as proposed in the President's budget message to Congress carried with it the assumption that the carryover funds, an unprecedented $34.5 million, would

make a total of $86.9 million available for RMP fiscal 1972 activities. Yet it had been increasingly difficult as the year passed to persuade the HEW budget managers, and, later, the Office of Management and Budget, to release these carryover funds. The proposed $86.9 million funding level for all of the 56 RMP regions represented a cut of $20 million in one year. As the early months of 1971 passed, the Administration reduced RMP funding levels and it became increasingly probable (if the views of the then-Secretary of HEW Elliott Richardson and his colleagues were as pessimistic as they seemed) that the $34.5 million would not be awarded for Regional Medical Programs, but would be retained at year's end to be carried over to fiscal 1972.

Coordinators of the 56 RMP regions felt that some effort should be made directly with the Secretary's office to argue for the release of more money. Seven representatives of the RMP's, the American Medical Association, the Association of American Medical Colleges, and the Kidney Foundation met with Secretary Richardson and several of his colleagues in May. The meeting began with a decidedly negative cast, but ended with a renewed interest on the Secretary's part in the accomplishments of RMP's and an unstated pledge to seek further responsibilities for Regional Medical Programs. There was no agreement on the release of the $34.5 million, but RMP's were charged that spring with helping to define "health maintenance," to set criteria for quality in health maintenance organizations and to develop and set in motion quality control activities. It seemed to the RMP's then, if not in later perspective, that they had won their point and the Administration did not, after all, intend to phase out the program.

A $10 million supplemental appropriation for RMP's in fiscal 1971 was heavily endorsed by Congress to help restore some of the momentum lost to the programs through the Administration cutbacks, and the Administration adopted a concept of level funding for Regional Medical Programs for fiscal 1972. Toward the end of that election year, however, when it became apparent that Caspar W. Weinberger was to move from his position as Director of the Office of Management and Budget to Secretary of HEW, RMP coordinators began to feel apprehensive about the program. Their gravest concerns were realized when the President's health budget for fiscal 1974 was published, with Regional Medical Programs slated for oblivion by June 30, 1973.

Arguments were heard like drum-fire from Administration spokesmen that RMP's had been too closely linked to categorical disease activities and had not really served the needs of people (whereas an early 1973 HEW document covering the previous year showed that more than half of the 9.6 million people directly served through RMP auspices had been in primary and emergency care settings), and that RMP projects "have not been carried out according to any consistent theme or set of authorities." No one in authority bothered to add that it was because of the Administration's various mandates for change in the program's purposes and direction that "any consistent theme" failed to exist.

As Director of the OMB, Mr. Weinberger declared that (1) "It is not an appropriate use of federal funds to finance continuing education for professionals generally capable of financing their own education to improve professional competence"; (2) "Originally established to upgrade health care of persons threatened by heart disease, cancer, stroke, kidney disease and related diseases, the RMP's in recent years sought more to improve access to and generally strengthen the health care delivery system"; and (3) "Dismantling the superstructure of the RMP's will also reduce the competition for the limited staff available with the skills needed to make a contribution to improving the health service system in the U.S." He added that after an expenditure of nearly $500 million during the life of the program "there is little evidence that, on a nationwide basis, the RMP's have materially affected the health care delivery system."[2] Yet Administration spokesmen had called RMP the best link government had with health providers.

Congress was yet to be heard from but on February 1, 1973, the Administration sent telegrams to all RMP coordinators, requiring that plans for phasing out operations by mid-year be submitted by March 15. The Administration began impounding funds for a wide range of programs, many of them, including RMP, in health. The RMP's began dismantling their operational and program staffs, and many patients who had been helped by the specialized services brought into being through RMP training and demonstration projects no longer could receive the individualized

and often highly technical aid. Although RMP's nationally represented in dollars a very small part of the programs that Mr. Weinberger indicated he would cut or discontinue, he probably mentioned RMP more often than any other program in his early 1973 public discussions of the need to reduce federal spending. During this period Congressional leaders reiterated their intent to keep RMP and other health programs alive.

Congress had before it the extension of the 16 programs contained in the Public Health Service Act, the legislative authorization for which ended on June 30, 1973. It was generally agreed that many provisions of the PHS Act needed to be revised and the stratagem to renew the Act for one year in order to allow sufficient time for reflection on the revamping of the code was adopted with overwhelming support. The Administration did not favor the blanket one-year extension and Mr. Weinberger took the unusual step of lobbying Congress personally to argue against the bill; but it was passed unanimously in the Senate, by a vote of 94-0, and had an overwhelming 372-1 tally in the House of Representatives. Mr. Nixon signed the measure and it became law in late June.

Then began some additional confusions and uncertainties as various levels of the Administration argued that funds could or could not or would or would not be released before June 30. Some $6.9 million in funds was released to the regions on the last day of the fiscal year with the stipulation that they could not be spent and the remaining impounded funds were incorporated in the law suit filed against the government by the National Association of Regional Medical Programs.

The one-year extension of the Public Health Service Act had become law, but since the Administration had expected that Regional Medical Programs would expire by June 30, except for the necessary tidying up that might carry through until February 15 at the latest, there were no plans for the program once fiscal 1974 began on July 1. Consequently there were no directions for several weeks about what was expected. Three of the 56 regions were closed down because the Administration believed them to have been demonstrably inadequate. Finally, on September 7, a new mission statement was issued outlining five program areas, to which RMP's were to be restricted: quality care assurance, emergency medical services, hypertension, kidney disease and development of new and more effective manpower utilization and training programs and assistance to comprehensive health planning agencies in carrying out the provisions of Section 1122 of the Social Security Admendments of 1972. Again, this represented a significant change in the program.

As the law suit progressed, it became apparent that the RMP's had more than a good chance of winning their case. Finally on February 7, 1974, the court ordered Secretary Weinberger to pay the $126 million in impounded fiscal 1973 and 1974 funds to the nation's Regional Medical Programs. While the Administration could appeal the verdict, the court required that the orders be carried out immediately, regardless of appeal.

On the second major point in the suit, namely that the RMP's be relieved of the mandatory termination date of June 30, 1974, the court found as a "conclusion of law" that "operational activities" of RMP's "should be permitted to proceed unhindered" by HEW or the Office of Management and Budget, "and this should be done until Congress indicates a contrary intention." The conclusion apparently allows the possibility of keeping selected RMP projects operating through fiscal 1975.

In addition to the order on release of funds and a relaxation of the June 30, 1974, termination date for RMP's, the court lifted the program restrictions imposed by the HEW Secretary in the September 7, 1973, directive containing the "priorities and options" section limiting RMP activity to the five major areas. The court found that HEW may legitimately be faced with time and funding constraints because of reduced RMP activity, and that its managers must be allowed to find ways to make the program as effective as possible. "However, they must do so in a manner consistent with congressional, not self-imposed, time and budgetary limitations." In addition, the court found, "The defendant administrators may not refuse to accept applications for programs in subject areas that are within the purposes outlined by the statute." The court also ordered the defendants to "rescind in writing all directives inconsistent" with its order "and notify recipients of such directives" that they are no longer applicable. The February 7 order became effective immediately and the court ordered the government to pay the costs of the suit.

If the court order prevails and its intent is obeyed, the RMP's programmatically can return to their earlier purposes, at least until Congress

acts on any extension of the Public Health Service Act.

In a short span of time, the program's purposes have been bent and twisted from improving the quality of care to creating new care, to controlling the cost of care, and now supposedly back to the intent of the law. And those same forces which caused the twisting and turning cried the loudest about the lack of "any consistent theme."

The future for the nation's health programs is in the hands of Congress. The expiration date of June 30, 1974, for most of the Public Health Service Act is rapidly approaching and it is doubtful if there is time to revamp all of the programs before that date. Some or most will probably be extended for one more year to allow time for hearings and debate.

During early 1974 there have been moves to combine the functions of planning, regulation, improvement and implementation of care into one organization at the local level. It is to be hoped we can avoid this pitfall. Planners are not regulators by nature or training, and should not be assigned regulatory functions. What we need from planning is a plan which indicates community-health needs—that is, a graphic indication of the deficits and excesses that exist in terms of health care services. Regulation, to the extent that we have it, should give major consideration to the plan when decisions about the health care system are made. But the same people should not perform both functions if objectivity and justice are a desired result. Nor are regulators and planners the best implementers of services. Implementation requires the skills of those who have had the experience of providing service. Quality determinations should be based on provider research and experience. To mix the three functions in one staff and organization is tantamount to placing the legislative, judicial and administrative function in one unit. Equitable conclusions would be hard to achieve. RMP has proven itself to be the best implementer of services in terms of access and quality based upon provider experience. This resource should not be wasted.

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Refer to: Weinberger CW: The guideposts in the RMP odyssey (Government and Medicine). West J Med 121:158-160, Aug 1974

The Guideposts in the RMP Odyssey

CASPAR W. WEINBERGER
Secretary of Health, Education, and Welfare

THE CHRONOLOGY of the Regional Medical Programs extends through one of the most turbulent decades in the history of American health care.

From 1964—when the Report of the President's Commission on Heart Disease, Cancer and Stroke recommended the development of regional complexes of medical facilities and resources—until today, no fewer than 38 laws directly affecting the nation's health care system, not including appropriations legislation, have been enacted. Federal expenditures for the nation's health have risen from about $4 billion in fiscal 1965 to $24.6 billion for fiscal 1972, with $26.3 billion requested by the President for existing health programs in fiscal 1975.

The programs which have been conducted under this legislation, supported by billions of tax dollars, have contributed substantially to improvements in the national availability of health facilities and health manpower and in expanded access to these resources.

The number of active physicians in this country has increased from 280,461 in 1964 to more than 345,000 this year. The number of American medical schools has increased from 87 in 1964 to 114 today. The 1964 problem of scarce hospital beds has now become a problem of how to control the proliferation of unneeded beds and unnecessary duplicative facilities. If we are still confronted by problems in the distribution of health resources, we are at least on the verge of providing the individual citizen with the means for paying for those resources within his proximity. We can expect this period of accelerated progress in the delivery of health care to be capped by the enactment of some type of national health insurance.

If this has been a period of accomplishment, it has also been one of experimentation and learning. We have learned that producing more health manpower and facilities is not necessarily accompanied by improved geographic distribution of those resources. We have learned that improving the quality of health care says nothing about extending that improved care to those who are physically or financially remote from our centers of medical excellence. And we have learned that the price of an improved health care system is not cheap. Last year, expenditures for health care amounted to 7.7 percent of the nation's gross national product, compared with 5.2 percent in 1960.

The proliferation of approaches to American health problems attempted during the past decade has also shown us that a national policy of simply inaugurating a stream of new programs, each addressing only a part of the total health care delivery problem, simply adds to the already great federal health bill and postpones or hampers the task of marshalling federal resources into a comprehensive, coordinated effort.

The fact that these lessons were learned over a period of time, and not as of some precise date, eliminates such factors from any neat chronicle of the fortunes of some individual program—whether it be Regional Medical Programs, Hill-Burton, or health manpower—but the impact is there nevertheless. Further, especially in view of the proliferation of federal programs in the 1960's, a chronicle of the twists and turns of one program

EDITOR'S NOTE: Secretary Weinberger was invited to respond to the commentary "The Curious Odyssey of Regional Medical Programs" which appeared previously in the May issue of this journal. In his response the Secretary places the RMP odyssey in broader perspective and also gives us a glimpse of the future as he sees it. —MSMW

Reprint requests to: C. W. Weinberger, The Secretary of Health, Education, and Welfare, Washington, DC 20201.

should take into account the total context of federal activity within which those fortunes occurred, whether it included increased competition for federal funds, the development of opportunities for administrative improvements, the availability of alternative programs to carry on the work, the implementation of changed views of what constitutes federal responsibility, and the assigning of higher priorities to problems previously submerged.

Even when these considerations are admitted into the discussion of the history of a particular program, there is room for honest disagreement, variations in interpretation, and shades of opinion. The judicial system is as legitimate an avenue to resolving those important differences as direct approaches to the legislative or the executive branches.

Failure to acknowledge that both problems and policies can change and that not everyone will agree with the revised position is to present a distorted picture of seeming inconsistencies, contradictions, and imagined vendettas.

The initial concept of Regional Medical Programs was to provide a vehicle by which scientific knowledge could be more readily transferred to the providers of health services, and by so doing, improve the quality of care provided, with emphasis on heart disease, cancer, stroke, and related diseases. That this original purpose has been broadened or revised or that some categories have been rescinded was inevitable in light of an improved perception of the nature of the nation's health care delivery problem over the past decade. That the utility of the RMP approach in coping with present problems and priorities has been short of the mark, is neither surprising nor a reflection on the integrity or competence of the individual RMPs. Despite the value of the relationships established by the RMPs over the past several years, the RMPs in their present form were simply never envisioned as a vehicle for addressing the comprehensive scope of health care delivery problems in the manner which we believe will be effective and is required today.

From the outset, the RMP has had great difficulty in defining a clear role for itself in concentrating its efforts and resources on even a few, well-selected target areas. At the same time, it has been unsuccessful in reconciling the conflicting and changing emphasis between categorical disease activities and comprehensive health care problems. More than half a billion dollars has been expended via the RMPs in an effort which has neither been true to the program's initial objectives nor sufficiently flexible to fulfill a more comprehensive mission. As a result of court action, another $218 million is being directed into this dubious direction.

Even with the original strong emphasis of RMP on regionalization there is little evidence—and only with regard to kidney disease—that the RMPs have in many areas produced the regionalized systems of health care originally envisioned at the program's outset.

There is no significant evidence that the RMPs have achieved their goal of getting research advances into regular large-scale practice. The training programs undertaken are typically of limited scope and duration, and there is no substantiating evidence that these have had a significant impact on actual medical practice or in demonstrating improved quality care.

A major problem with respect to RMP has been the high cost of maintaining the program, or core, staffs in each of the 56 regions. A significant part of the overall RMP effort and funds has gone to pay for program staff and their activities, including administration, consultation, project development and management, and evaluation.

Another continuing problem has been the relationship of RMPs to Comprehensive Health Planning. In some areas, RMPs and CHPs have worked closely together in a beneficial way, but often their individual roles have been hard to differentiate. It is difficult to have a CHP agency with responsibility for the health planning for an area while another federally-supported program, an RMP, is implementing activities in that same area based on its own planning and priorities. What has frequently happened is that, since the RMP has had funds available to carry out operational activties, its planning has become the deciding force of what is done in a given area. This has not always been consistent with broader community and consumer health needs and interests.

The opportunity for such conflict may be seen from the fact that of the 56 RMP regions, 34 are exactly coterminous with state boundaries and served by CHP agencies.

A solution to this problem has been advanced by the Administration in the form of the proposed

Health Resources Planning Act (S. 3166), which would replace the present RMP and CHP authorities, which expired June 30. The bill has two major purposes: First, to assist the nation's health care system to plan more effectively to provide the resources necessary to meet the nation's health care needs; and second, to grant assistance to states to pay part of their costs in regulating proposed capital expenditures and rate increases for health care.

This proposal provides for a clear distinction between planning and development activities on the one hand and regulatory functions on the other. We believe that the planning function should rest at the local level. It is at this level at which local problems are best understood and can best be solved. On the other hand, we feel that regulatory functions should be placed at the state level, recognizing that regulation is more clearly a government function. We plan, however, that the state regulatory bodies will rely heavily on the local planning bodies for advice in carrying out their functions.

Moreover, far from total abandonment of usable elements of existing agencies and programs involved in the present fragmented health planning process, the proposal provides for an orderly transition to bring those agencies into a new alignment of Health Systems Agencies envisioned in the bill. Hill-Burton, CHP, and RMP programs would be eligible to receive technical assistance from the Department of Health, Education, and Welfare to enable them to qualify for provisional certification as a Health Systems Agency under the proposal. The provision of that assistance could be conditioned upon a reorganization of the recipient entity or its merger with another entity.

Of the health planning bills currently being considered by the Congress, with few exceptions, most can be characterized by their similarities to the Administration bill rather than their differences. It appears that somewhere in the chronology of RMP fortunes, the issue has become not whether RMP should remain or be terminated, but whether RMP is willing to shed its present nomenclature and limitations and participate in the more comprehensive approach to improving health care which is being developed today.

TAB V

Biographical Sketches of Directors of Regional Medical Program

BIOGRAPHICAL SKETCHES OF DIRECTORS OF REGIONAL MEDICAL PROGRAM

1966-68 Robert Q. Marston, M.D.

1968-70 Stanley W. Olson, M.D.

1970-73 Harold Margulies, M.D.

1973-75 Herbert B. Pahl, Ph.D.

Biographical Sketches of RMP Directors

Robert Q. Marston, M.D.

Robert Q. Marston was born in Toana, Virginia on February 12, 1923. After graduating from Virginia Military Academy in 1943, he attended the Medical College of Virginia, where he obtained his M.D. degree in 1947. Selected as a Rhodes Scholar, Dr. Marston then spent the next two years studying at Oxford University in England with Professor Howard Florey, a Nobel Prize recipient for his work with penicillin.

After returning to the United States in 1949, he took an internship at Johns Hopkins Hospital, then spent the next year in a residency at Vanderbilt University Hospital. From 1951 to 1953, Dr. Marston served in the American Forces Special Weapons Project at the National Institutes of Health (NIH), studying the role of infection following whole body radiation. After army service, he took another year of residency at the Medical College of Virginia.

Having received a four year Markle Fellowship, Dr. Marston was appointed Assistant Professor of Medicine at the Medical College of Virginia and then Assistant Professor of Bacteriology and Immunology at the University of Minnesota. He returned to Medical College of Virginia in 1959 to assume an Associate Professorship in Medicine, at the same time serving as Assistant Dean.

In 1961, Dr. Marston was named Director of the University of Mississippi Medical Center and Dean of its School of Medicine. In 1965 he was appointed Vice Chancellor of the University, while continuing on as Dean. From 1961 to 1966, Dr. Marston served on a consultative review committee for the Division of Hospital and Medical Facilities within the Department of Health education and Welfare (HEW).

On February 1, 1966, Dr. Marston was appointed as the first Director of Regional Medical Programs, which was originally located in NIH. He also served as an Associate Director of NIH. Dr. Marston's tenure as Director of Regional Medical Programs lasted until 1968. On April 1, 1968, Dr. Marston was named Administrator of the Health Services and Mental Health Administration, under the reorganization of the Department of HEW. But in September of that year he resigned that position to accept the directorship of NIH, which he held until 1973.

On January 21, 1973, he became Acting Director of the National Institute of Neurological Diseases and Stroke, but left in April of the same year to become a scholar-in-residence at the University of Virginia. Dr. Marston was named president of the University of Florida at Gainesville in January, 1974, holding the presidency for 10 years, until 1984. He remained at the University of Florida as Emeritus President, Emeritus Professor of Medicine and Joint Professor of Fisheries and Aquaculture.

Among distinctions bestowed upon him, Dr. Marston was named the first distinguished fellow of the Institute of Medicine, National Academy of Sciences. He has served as a member of many health and medical organizations: member of council of the Institute of Medicine, National Academy of Sciences; member of the board of directors of Johnson and Johnson; member of the National Association of State Universities and Land Grant Colleges; fellow of the American Public Health Association; honorary member of the National Medical Association; honorary member of the American Hospital Association.

Stanley W. Olson, M.D.

Stanley Olson was born February 10, 1914 in Chicago. He earned his B.S. from Wheaton College in 1934 and then went on to study medicine at the University of Illinois, where he took his M.D. degree in 1938. Dr. Olson took an Internship at Cook County Hospital in Chicago in 1938 and remained there until 1940. He was awarded a fellowship from the Mayo Foundation and earned an M.S. in Medicine from the University of Minnesota in 1943.

Dr. Olson then served as an Assistant Director of the Mayo Clinic and for the same period, 1947-1950, held a position as Instructor in Medicine at the Graduate School of the University of Minnesota. From 1950-1953, Dr. Olson was Dean of the College of Medicine at the University of Illinois, and Medical Director of the University's Research and Educational Hospitals. He became Dean of the College of Medicine at Baylor University where he remained in that capacity until 1966. From Baylor he moved to Vanderbilt University, and until 1968, held a Professorship in Medicine along with a clinical Professorship at Meharry Medical College.

Dr. Olson was a member of the National Advisory Council for Health Research Facilities within NIH from 1963 to 1967. He served from 1964 to 1965 on a review panel of the Public Health Service which oversaw the construction of medical schools. Dr. Olson was named Director of the Tennessee Mid-South Regional Medical Program in 1967. In 1968 he was appointed as Director of the Division of Regional Medical Programs and continued in this position until 1970. He left this post to take up an appointment as President of the Southwest Foundation for Research and Education from 1970 to 1973. Dr. Olson then joined the College of Medicine Northeastern Ohio University as Provost until 1979, when he became Professor of Medicine and Emeritus Provost.

Positions held concurrently by Dr. Olson during his career include: consultant for the State University of New York; member of the Medical Advisory Panel of the U.S. Office of Vocational Rehabilitation Administration, 1960-1965; member of the committee on medical school-Veterans Administration Relations, 1962-1966; member of the National Advisory Commission on Health Manpower, 1966; and consultant on Medical Education, 1979. He has also been Vice-president of the American Association of Medical Colleges,

1960-1961, and is a Fellow of the American College of Physicians.

Harold Margulies, M.D.

Dr. Margulies was born in Sioux Falls, South Dakota on February 13, 1918. He earned an A.B. from the University of Minnesota in 1938 and a B.S. from the University of South Dakota in 1940. He studied medicine at the University of Tennessee and was granted his M.D. there in 1942. Later, in 1948, he acquired an M.S. through his work in the Mayo Foundation.

Dr. Margulies served his internship at Iowa Methodist Hospital in Des Moines, from 1943-1944. He was a Fellow in internal medicine at the Mayo Clinic from 1944-1945 and also during 1946-1949. Dr. Margulies practiced medicine, having specialized in internal medicine and cardiology, in Des Moines from 1949-1961. He then became professor of medicine at Indiana University.

He served overseas in the AID (Agency for International Development) Contract at the Postgraduate Medical Center in Karachi, Pakistan, 1961-1964. He then relocated to Alexandria, Egypt, to be an advisor on Medical Education in the World Health Organization, 1965-1966. Dr. Margulies's service abroad also included a role as Associate Director of the Division of International Medical Education of the Association of American Medical Colleges and as Director of the AID Contract project from 1965-1967.

Dr. Margulies returned to the U.S. and was appointed Associate Director of Socio-Economic Activities of the AMA in Washington, from 1967-1968. He then took the position of Secretary of the Council on Health Manpower for the years 1968-1969. He transferred to the Health Services and Mental Health Administration to be Deputy Assistant Administrator for Program Planning and Evaluation from 1969-1970. It was in 1970 that Dr. Margulies was appointed Director of the Regional Medical Programs Service, a post which he held until 1973.

Concurrent positions that Dr. Margulies has held throughout his career include that of consultant in internal medicine for the Veterans Administration, 1949-1961, White House Office of Science and Technology, 1966-1967, and Diplomat of the American Board of Internal Medicine. Among his many distinctions, he is a Fellow of the American College of Physicians and of the American Public Health Association.

Herbert B. Pahl, Ph.D.

Dr. Pahl was born in Camden, New Jersey, on August 14, 1927. He was educated at Swarthmore College, graduating with a B.A. in 1950. At the University of Michigan he did his graduate work in biochemistry, earning an M.S. in 1952 and a Ph.D. in 1955.

He began his post-graduate career as a Fellow of the National Cancer Institute, and of the Sloan-Kettering Institute, from 1955-1957. Dr. Pahl then took an assistant professorship at Vanderbilt University in biochemisty in 1957 and remained there until 1960.

He entered the National Institutes of Health in 1960 and until 1962 his service there was as the Executive Secretary of the Graduate Research Training Grant Program. He moved to the Special Research Resources Branch and was first its assistant chief and then its chief during 1962-1964. Dr. Pahl continued as chief of the General Research Support Branch from 1964-1966. From 1966-1969 he was the Executive Secretary of the Committee on Research of Life Sciences of the National Academy of Sciences-National Research Council. Returning to NIH, he was appointed deputy associate director of science programs of the National Institute of General Medical Science in 1969.

His involvement in the Regional Medical Programs Service began in 1971, at which time he was appointed its Deputy Director. In 1973 he was promoted to the Directorship of the Regional Medical Programs Service and continued in this position until 1975.

From 1975 until 1982 Dr. Pahl was staff director of the Committee to Study National Needs for Biomedical and Behavioral Science Research Personnel, which operated within the National Research Council of the National Academy of Sciences. His latest appointment was to the Program Directorship of the Cancer Center Branch of the National Cancer Institute at NIH. He assumed this role in 1984. Dr. Pahl is a member of the American Association for the Advancement of Science.

TAB VI

Budget History

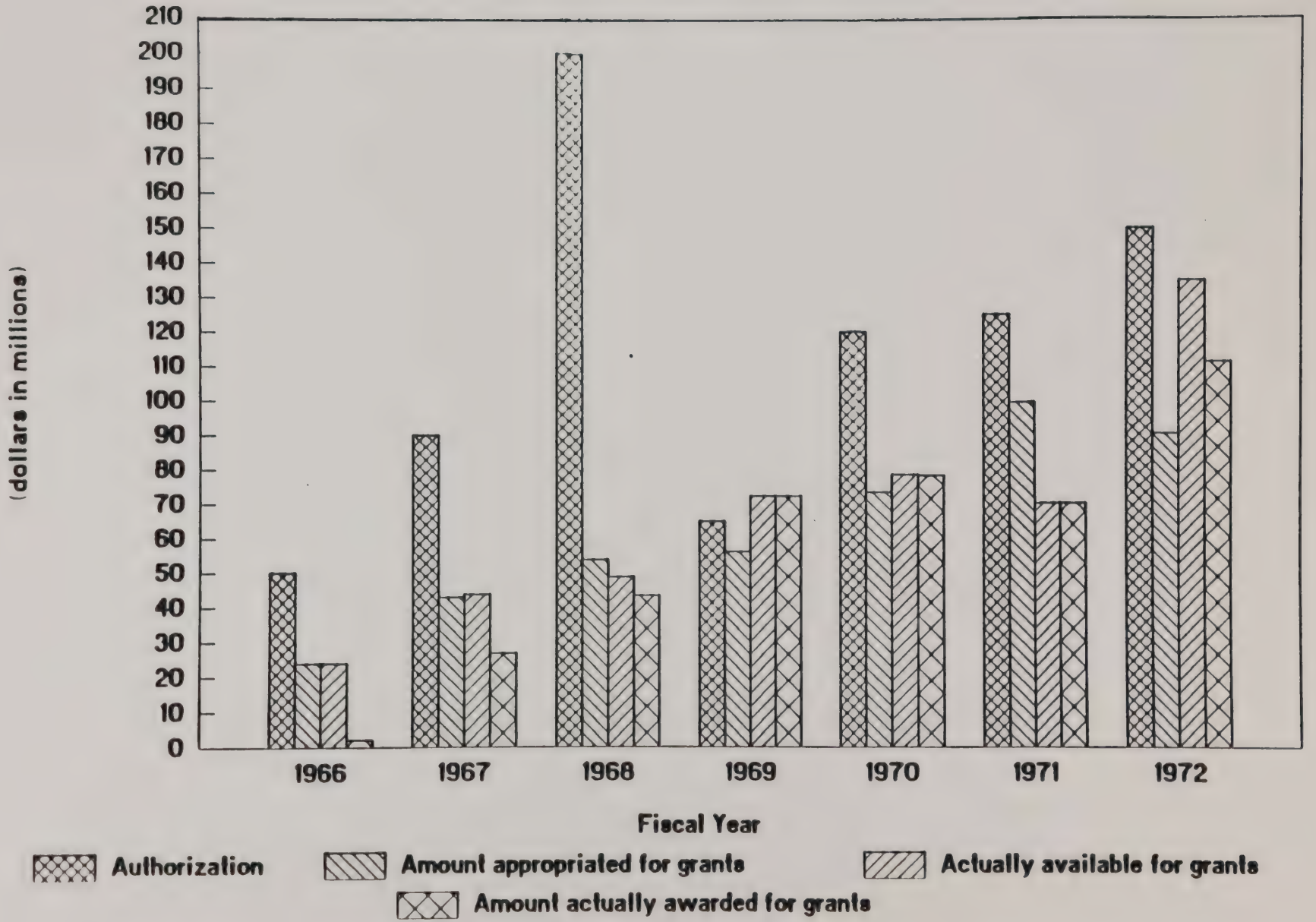
BUDGET HISTORY

The budget figures in the table and graph that follow have been taken from Regional Medical Programs Fact Book (published by the Regional Medical Programs Service in November, 1972). Further research is now in progress to try to confirm and expand upon these figures. We do not yet have data for the period after 1972, when RMPs were being phased out.

APPROPRIATIONS AND BUDGETARY HISTORY
(dollars in thousands)

	Fiscal Year 1966	Fiscal year 1967	Fiscal year 1968	Fiscal year 1969	Fiscal year 1970	Fiscal year 1971	Fiscal year 1972
Authorization	$50,000	$90,000	$200,000	$65,000	$120,000	$125,000	$150,000
Amount appropriated for grants	$24,000	$43,000	$53,900	$56,200	$73,500	$99,500	$90,500
Actually available for grants	$24,000	$43,934	$48,900	$72,365	$78,500	$70,298	$135,000
Amount actually awarded for grants	$2,066	$27,052	$43,635	$72,365	$78,202	$70,298	$111,400

Appropriations and Budgetary History



TAB VII

Summaries of Key Reports and Hearings

SUMMARIES OF KEY REPORTS AND HEARINGS

Report of the President's Commission on Heart Disease, Cancer, and Stroke, December, 1964.

Heart Disease, Cancer, and Stroke Amendments of 1965, Report of the Senate Committee on Labor and Public Welfare, Subcommittee on Health, June 24, 1965.

Heart Disease, Cancer, and Stroke Amendments of 1965, Report of the [House] Committee on Interstate and Foreign Commerce, September 8, 1965.

Report of Regional Medical Programs to the President and the Congress, Submitted by William H. Stewart, M.D., Surgeon General, U.S.P.H.S., June, 1967.

Hearing before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce, House of Representatives, ...on...Oversight...of...Regional Medical Programs, May 8, 1973.

Report of the President's Commission on Heart Disease, Cancer, and Stroke December, 1964

This commission, chaired by Michael DeBakey, M.D., was charged with responding to President Johnson's Health Message of February, 1964. The Report was the result of nine months of testimony from 166 health care experts and consultation with 60 health organizations and associations. The report was organized in two parts. Part I identified the national scope of the problem of the three leading causes of death of the time: heart disease, cancer and stroke. Part II was in the form of a list of 35 recommendations, which basically advised that a national network be established to conquer these diseases.

Part I

This section of the report included data about the magnitude of the problems resulting from these three diseases. They accounted for 71% of all deaths for the year 1963. Each disease was presented separately. The scope of each disease was analyzed in terms of number of deaths, disability caused, economic impact, and progress made to date.

Part II

This section proposed 35 recommendations for establishing a national network to conquer the diseases. Of those 35, the salient proposals were as follows:

> That the Federal Government has a responsibility toward every citizen, to protect their health against these three killers, and to support research to combat these diseases.
>
> That a program of grant support be undertaken to support medical complexes of hospitals, medical schools and other institutions; and that there be growth in the number of "centers of excellence" in education and research.
>
> That the Vocational Rehabilitation Administration launch a 5-year program for rehabilitation of patients with these diseases.
>
> That national programs be established for the detection of cervical cancer; for continuing education; for prevention; for 25 non-categorical research institutes; for categorical research centers in the area of the three diseases; for clinical fellowships; for recruitment and training of personnel in all pertinent areas; for the training of specialists in health communications; for review of manpower requirements; for support of the National Library of Medicine; for improved methods of statistical collection and study; for establishing a National Drug Information Clearinghouse to be affiliated with the National Library of Medicine; and that research of a collaborative nature be supported outside of the U.S.

Heart Disease, Cancer, and Stroke
Amendments of 1965
Report of the Senate Committee on Labor and
Public Welfare, Subcommittee on Health
June 24, 1965

Presented by Senator Hill of Alabama, this report, in connection with Senate Bill 596, included a review of the Report of the President's Commission. The Senate subcommittee report suggested that Regional Medical Complexes be established to address the recommendations of the Report of the President's Commission. Endorsements from the American Heart Association, American Cancer Society, American Hospital Association and American Public Health Association were included.

The Regional Medical Complexes were designed to link medical centers, research centers, and diagnostic and treatment stations of community hospitals. The intention was to widen the availability of the best medical care. The other provisions of Senate Bill 596 were described: grants were to be authorized for the planning and development of complexes, for research, for training, for prevention, and for demonstration of patient care in connection with each of the three leading diseases. The bill was drafted to provide flexibility for existing local experience.

The subcommittee advised that the early emphasis of the program be on planning, so as to benefit best from local initiative. The role of the advisory group and the emphasis on patient care were mentioned. The report included the Surgeon General's recommendation that the proposed programs be placed in the National Institutes of Health. A National Advisory Council was expected to foster coordination of the complexes.

The expected advantages to be derived from such complexes were new opportunities for clinicians to avail themselves of the latest advances, better training, cooperation between research centers and hospitals, and optimum use of expensive facilities. These advantages hopefully would lead to a new degree of access for those afflicted with the leading three diseases.

The report ended with a summary of explanations of each part of the bill, S.596.

Heart Disease, Cancer, and Stroke Amendments of 1965
Report of the [House] Committee on Interstate and Foreign Commerce
September 8, 1965

Companion bills, H.R. 3140 and S. 596, were introduced into the House and Senate to fulfill the recommendations of the President's Commission headed by Michael DeBakey, M.D. This report accompanied the House version of the bill (H.R. 3140). As a Congressional committee report, it was of the same format as the report of the Senate subcommittee on the companion bill.

The report reviews the House bill, which was similar to the Senate version. A statement from the president of the AMA, Dr. James. Z. Appel, was included in this report. Appel raised the AMA's objections to the bill, which concerned the fear of a federally sanctioned program impinging upon the free, private system of hospitals and physicians. Because the intent of the bill, as explained by Secretary of HEW Anthony Celebrezze, was to make use of existing facilities and to limit new construction, the phrase "regional medical complexes" was changed to "regional medical programs."

The report also explained the following changes: a reduction in the time period of effectiveness of this bill from five years to three years, after which point new legislation would be required to continue the program; patients could be referred only by a private physician to a program and only for the purposes of research or training. Also, the requirement for diagnostic and treatment centers was replaced by simply requiring participation by local hospitals.

The report indicated the need for extensive funding of planning before implementation of a vast program. The priorities of continuing education and the extension of the latest advances in medical care to rural and suburban communities were indicated. A section by section description of the bill follows at the end of the report.

Report on Regional Medical Programs
to the President and the Congress
Submitted by William H. Stewart, M.D.
Surgeon General, U.S.P.H.S.
June, 1967

This report fulfilled a requirement of P.L. 89-239 that the Surgeon General give an evaluation of Regional Medical Programs by June, 1967. The report discusses activities, progress, issues and problems of RMPs to date. It provides information on the planning grants and operational grants awarded to date. It also lists the members of the National Advisory Council and the RMP Review Committee, as well as the consultants to the Division of RMPs. Excerpts from the annual progress reports of the various RMPs are also included. Other materials included in the report are the procedures for review and approval of operational grants, basic data such as lists of staff, a copy of the law 89-239, and the RMP regulations.

At this point, 47 planning grants had been awarded, totaling about $24 million; 4 operational grants had been approved for a total of $6.7 million.

Among the recommendations made in the report were the following: referrals by dentists should be included in RMP activities; Federal hospitals should receive assistance in the manner that community hospitals received aid; that a means of meeting the space needs of the program should be found; a five year extension of the original commitment should be enacted, and the program should ultimately be established on a continuing basis. Construction of essential facilities was called for, especially in the area of continuing education. Also mentioned was the need for creating integrated data banks and communications systems.

Hearing before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives . . . on . . . Oversight . . . of . . . Regional Medical Programs May 8, 1973

These hearings determined the fate of Regional Medical Programs. It was decided that RMPs were to be phased out. No grant funds were to be included in the President's budget request for fiscal year 1974. The hearings gave the rationale for this decision.

Dr. John S. Zapp, D.D.S., Deputy Assistant Secretary for Legislation, Department of HEW, testified that the Regional Medical Program Service (successor of the Regional Medical Programs Division) was ineffective. Zapp's testimony highlighted perceived RMP weaknesses. He mentioned a lack of a clearly defined role, a lack of reconciliation between categorical disease activities and comprehensive health care problems. He claimed that for fiscal year 1972, 40% of RMP funding went toward administrative purposes. RMPs were seen as impinging on the territory of Comprehensive Health Planning (CHP). Dr. Zapp foresaw CHP overtaking RMPs in areas such as data systems. He considered other RMP functions to be redundant since similar functions were carried out in other areas of HEW.

Rep. Richardson Preyer (NC) countered by noting that physicians who made volunteer efforts in RMPs would lose trust in future government programs when they saw the fate of RMPs.

Dr. Harold Margulies, M.D., the Director of the Regional Medical Programs Service, testified that he believed continuing education efforts were not effective. But he did credit RMPs with establishing coronary care units "in a great range of hospitals around the country." He estimated that, as Dr. Zapp charged, 40% of funding was going toward administrative purposes. Dr. Margulies in general agreed with the assessment that the RMPs had "so little direction that the program has sort of lost its way."

Rep. James Hastings (NY) suggested that the best aspects of RMPs be continued and enjoined to CHP so as to "try to develop some national health policy, which I think we are lacking today. . . ." Rep. Hastings also asked for a possible one year extension for RMPs to work on such a proposal.

Testimony from various other individuals was heard. For example, a group of leaders from five of the RMPs testified in favor of continuation of the program. They pointed out such accomplishments of RMPs as promoting cooperative ventures between private and government agencies, attracting high quality staff, catalyzing innovation, and educating health professionals in new skills.

Dr. Faxon Payne, advisory chairman for the Tennessee-Midsouth

RMP, identified the constructive accomplishments of that RMP. Among those accomplishments were, a new, cost-reducing, cooperative venture among area hospitals in supplies; the building of two coronary care units; and a toll-free telephone line for physician consultation. The grassroots aspect of the program meant that local officials were able to determine funding according to their specific needs, and thus waste was minimal. This assertion contradicted Dr. Zapp's testimony of the supposed excess under which this program operated.

One of the criticisms of the detractors of RMPs was that physicians did not need to be provided with continuing education services, because those resources existed. In addition, the income of the average physician was so high that they should be expected to pay for their own continuing education courses through existing agencies or institutions. Dr. William J. Hagood, Jr., M.D., speaker of the House of Delegates, Virginia Medical Society, member of the regional advisory group of the Virginia RMP, addressed this criticism. First, Dr. Hagood mentioned that other health care personnel (e.g., nurses, nurse practitioners, technicians) of lower income than the physician were receiving the majority of continuing education in his RMP. Second, he pointed out that the Virginia RMP provided consultants to physicians in the field, so that the education could be applied directly to practice. Such education indeed was deemed more useful to improving health care directly, without the physician having to close his practice for days to attend seminars or lectures at some other location. As for administrative waste, Dr. Hagood pointed to the central office of the Regional Medical Programs Service, under HEW, as the root of many problems. The inefficiency of the main office was to blame, and not the 56 individual RMPs.

Another issue raised was the supposed ambiguity and hence overlap of RMPs with the Comprehensive Health Planning Service. The latter, as a so called "Section 314(b)" agency -- a designation that was enacted under Public Law 91-515 -- had as its mission, the decentralization of planning, so that each area agency would plan according to its own priorities. The emphasis was on underserved areas, minorities, and problems of nursing homes.

Thus, Rep. Ancher Nelsen (MN) charged "Could it be that the two programs [RMPS and CHPS] would run better as one, and that they should be merged?" To which a fellow Minnesotan, Dr. Robert E. Carter, M.D., Dean of the University of Minnesota Medical School, responded that the one, RMPS, was geared toward implementation, while the other, CHPS, had its emphasis on planning.

The testimony of Dr. R. Ingall, M.D., executive director of the Lakes Area Regional Medical Program was an eloquent polemic against the arguments of the detractors. He stated that "RMP is governed by the people and for the people. . . . RMP's recognized that authority handed up was much greater than authority handed down . . . ." This was the mission of decentralization.

In his testimony, Dr. H. Phillip Hampton, director of the Florida Regional Medical Program, pointed out that the recently established Professional Standards Review Organization (PSRO) was one organization that was dependent on RMP services in technical support for its proper functioning.

Dr. William McBeath, M.D., Director of the Ohio Valley RMP, addressed the issue of the categorical mandate of RMPs. He related that the Ohio Valley RMP was burdened by a change in its priorities from on high, and that to receive funding from 1969 onward, it had to place greater emphasis on ambulatory care. The ever changing mandate was a reason for lack of focus and the discontinuity in projects. Because of funding cuts, projects could be undermined before they got off the ground.

Vacillation in RMP goals came as a result of the so-called "Finch Report," a white paper that came out of the Secretary of HEW's office. Robert Finch served as Nixon's first appointed Secretary of DHEW until June, 1970. This was a period of intense flux in HEW. The "Finch Report" of this period stressed the need to serve low-income groups, single mothers with children under five, Indians, migrant workers, and other disadvantaged groups. As a result, Dr. Paul Ward, Director of the California RMP, related in his statement that coordinators of the various RMPs met in Atlanta to redirect RMPs according to the Finch priorities. The Finch Report therefore was the impetus that moved RMPs further off its categorical track. Reference was made by Dr. Ward to a meeting with Secretary Finch, in which a course was set by which RMPs were to proceed along these new priorities.

Dr. Ward outlined the guidelines by which funding was allocated. The first step in the allocation process was to seek the involvement of the existing local institutions and affiliates. The second step was to make an "assessment of need", something, which Paul Ward argued, should have been taken care of by a 314b agency (Comprehensive Health Planning.) The third step was to catalog resources of the region already in existence. The fourth was for the Regional Advisory Group to establish the priorities to be followed for funding in the region. The fifth step was to implement the funding for its operational purposes. This was followed by the evaluation process.

Dr. Ward also attacked John Zapp's assertion that 40% of RMP funding went to administration. Dr. Ward asserted that according to the "accepted classical definition of administration, it comes much more close to 7 percent than it does to the 40 percent [that Dr. Zapp claimed]." Dr. Hampton, director of the Florida RMP, also responded to the charge of uncontrolled administrative costs, and related that his program was spending less than 5% on such costs, by the federal definition. He continued that "If you take [into account] the entire core staff, all the expenses of the core staff which is far beyond administrative in their activities, it is only 14 percent."

Determined to give the RMPs their due, Dr. Ward credited them for developing ". . . more EMS [Emergency Medical Service] programs than any other single source in the United States. . ." and for extending care of some nature to more than 9 million persons in 1972.

The hearings also contained letters of support for Regional Medical Programs from organizations, including the American Nurses' Association and affiliated community hospitals, and also from individual physicians. Supplements on the budget, number of people served, evaluation procedures, and reports from individual programs were also included in the testimony.

TAB VIII

List and Map of RMPs

LIST OF REGIONAL MEDICAL PROGRAMS

RMP	Geographic Area
1. Alabama RMP	Covered the state of Alabama.
2. Albany RMP	Included 21 northeastern New York counties centered on Albany, with contiguous portions of southern Vermont and Berkshire County in western Massachusetts. Overlapped Tri-State and Northern New England RMPs.
3. Arizona RMP	Covered the state of Arizona.
4. Arkansas RMP	Covered the state of Arkansas. Overlapped in the northeast portion with Memphis RMP.
5. Bi-State RMP	Included southern Illinois and eastern Missouri counties centered on the St. Louis metropolitan area. Overlapped Illinois RMP.
6. California RMP	Covered the state of California. Overlapped Mountain States RMP in sections of Nevada.
7. Central New York RMP	Included 15 central New York counties centered on Syracuse, and the Pennsylvania counties of Bradford and Susquehanna.
8. Colorado-Wyoming RMP	Covered the states of Colorado and Wyoming. Overlapped Mountain States and Intermountain RMPs.
9. Connecticut RMP	Covered the state of Connecticut.
10. Delaware RMP	Covered the state of Delaware.
11. Florida RMP	Covered the state of Florida.
12. Georgia RMP	Covered the state of Georgia.
13. Greater Delaware Valley RMP	Included southeastern Pennsylvania (Philadelphia-Camden), northeastern Pennsylvania (Wilkes Barre-Scranton) and southern New Jersey counties. Overlapped New Jersey RMP.

14. Hawaii RMP	Included the state of Hawaii, American Samoa, Guam, and the Trust Territory of the Pacific Islands.
15. Illinois RMP	Covered the state of Illinois. Overlapped Bi-State RMP in the southern portion of the state.
16. Indiana RMP	Covered the state of Indiana. Overlapped Ohio Valley RMP.
17. Intermountain RMP	Included the state of Utah, portions of Wyoming, Montana, Colorado and Nevada. Overlapped Colorado-Wyoming and Mountain States RMPs.
18. Iowa RMP	Covered the state of Iowa.
19. Kansas RMP	Covered the state of Kansas.
20. Lakes Area RMP	Included seven western New York counties centered on Buffalo, and the Pennsylvania counties of Erie and McKean.
21. Louisiana RMP	Covered the state of Louisiana.
22. Maine RMP	Covered the state of Maine.
23. Maryland RMP	Covered the state of Maryland and York County, Pennsylvania. Overlapped in southern central Maryland with the Metropolitan Washington DC RMP.
24. Memphis RMP	Included the western Tennessee area centered on Memphis; northern Mississippi; northeastern Arkansas; portions of southwestern Kentucky; and three counties in southwestern Missouri. Overlapped Mississippi, Arkansas and Ohio Valley RMPs.
25. Metropolitan Washington DC RMP	Included the District of Columbia and contiguous counties in Maryland and Virginia. Overlapped Maryland and Virginia RMPs.
26. Michigan RMP	Covered the state of Michigan.
27. Mississippi RMP	Covered the state of Mississippi. Overlapped Memphis and Virginia RMPs.

28. Missouri RMP	Covered the state of Missouri, exclusive of the St. Louis metropolitan area.
29. Mountain States RMP	Included portions of Idaho, Montana, Nevada and Wyoming. Overlapped California, Intermountain and Colorado-Wyoming RMPs.
30. Nassau-Suffolk RMP	Included the counties of Nassau and Suffolk (Long Island) of the state of New York.
31. Nebraska RMP	Covered the state of Nebraska.
32. New Jersey RMP	Covered the state of New Jersey. Overlapped in seven southern counties with Greater Delaware Valley RMP.
33. New Mexico RMP	Covered the state of New Mexico.
34. New York Metropolitan RMP	Included New York City and Westchester, Rockland, Orange and Putnam counties.
35. North Carolina RMP	Covered the state of North Carolina.
36. North Dakota RMP	Covered the state of North Dakota.
37. Northeast Ohio RMP	Included 12 counties in northeast Ohio centered on Cleveland.
38. Northern New England RMP	Included the state of Vermont and three contiguous counties in northeastern New York. Overlapped Albany RMP.
39. Northlands RMP	Covered the state of Minnesota.
40. Ohio RMP	Covered the central corridor of the state from the northwest to the southeast.
41. Ohio Valley RMP	Included most of Kentucky (101 of 120 counties), southwest Ohio (Cincinnati-Dayton and adjacent areas), contiguous parts of Indiana (21 counties) and West Virginia (2 counties). Overlapped Indiana, Memphis, Tennessee MidSouth and West Virginia RMPs.

42. Oklahoma RMP	Covered the state of Oklahoma.
43. Oregon RMP	Covered the state of Oregon.
44. Puerto Rico RMP	Covered the Commonwealth of Puerto Rico.
45. Rochester RMP	Included ten counties centered on Rochester, New York.
46. South Carolina RMP	Covered the state of South Carolina.
47. South Dakota RMP	Covered the state of South Dakota.
48. Susquehanna Valley RMP	Included 27 counties in central Pennsylvania centered on the Harrisburg-Hershey area.
49. Tennessee Mid-South RMP	Included 84 counties in central and easatern sections of Tennessee and portions of southwestern Kentucky. Overlapped Ohio Valley RMP.
50. Texas RMP	Covered the state of Texas.
51. Tri-State RMP	Covered the states of Massachusetts, New Hampshire and Rhode Island. Overlapped in western Massachusetts with Albany RMP.
52. Virginia RMP	Covered the state of Virginia. Overlapped in northern section with Metropolitan Washington DC RMP.
53. Washington/Alaska RMP	Covered the states of Washington and Alaska.
54. West Virginia RMP	Covered the state of West Virginia. Overlapped in two counties with Ohio Valley RMP.
55. Western Pennsylvania RMP	Included 28 counties in Pennsylvania centered on Pittsburgh.
56. Wisconsin RMP	Covered the state of Wisconsin.

Regional Medical Programs